India

Operational Plan Report

FY 2010

Operating Unit Overview

OU Executive Summary

India has the third largest HIV epidemic in the world. According to the 2007 Government of India (GOI) national estimates, there are 2.31 million people living with HIV/AIDS (PLHIV). However, because India is such a large country, the estimated adult HIV prevalence is a mere 0.34% of the population. This low prevalence rate is misleading given that nominal elevations in the HIV/AIDS rates in India have global ramifications. Fortunately, since 1990 the Government of India has been dedicated to combating the HIV/AIDS epidemic through a series of progressively stronger national programs. The most recent National AIDS Control Program, Phase III (NACP III) has increased efforts to expand services and tailor interventions to the unique dynamics of the epidemic in India. Given NACP III's current momentum and significant advances in scale-up and capacity development, at the central and state level, reversing the epidemic is within reach over the next five to ten years.

India's success influences the global HIV/AIDS pandemic reaching the Millennium Development Goals and meeting UNAIDS principles of the "Three Ones." Working in close cooperation with the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and international partners, India is implementing "One" HIV/AIDS action framework, NACPIII, with "One" national AIDS coordinating authority, the National AIDS Control Organization (NACO). Now India is working towards unifying the country-level monitoring and evaluation (M&E) systems under "One" authority. PEPFAR/India is successfully implementing an aggressive transition from direct services to technical assistance. This fits well with the large scale $2.5 billion NACP III. The USG is strategically focusing on addressing the capacity gaps and TA needs at the national and state level in India to enhance GOI efforts to effectively combat HIV/AIDS.

The HIV/AIDS Epidemic in India

India has a concentrated epidemic with the highest prevalence among Most at Risk Populations (MARPs): female sex workers (FSW), men who have unprotected sex with men (MSM) and injection drug users (IDU). USG support predominately focuses on these MARPs along with bridge populations, pregnant women and Orphans and Vulnerable Children (OVC). HIV prevalence among men continues to be higher (0.45%) than females (0.27%). Out of the total estimated number of PLHIV, 39% are females and 3.5% are children. India has 3-4 million children affected by AIDS, out of which 95,000 children are living with HIV. Out of an estimated 27 million annual deliveries in India, approximately 85,000 infected women become pregnant and give birth to 25,000 infected babies each year. In 2008, 4.15 million pregnant women (15.3% of all pregnancies) received PMTCT services of which 19,986 tested HIV positive.

HIV estimates for India (2007)

Category	Estimation
Total population	1.027 billion
Number of people living with HIV (adults and children)	2.31 million
HIV prevalence (15-49 years)	0.34%
HIV prevalence among men (15-49 years)	0.40%
HIV prevalence among women (15-49 years)	0.27%

Source: HIV Sentinel Surveillance and estimation is conducted annually by NACO. The latest report available is HIV data 2007. The HIV Sentinel Surveillance data 2008 is expected by November 2009.

While India's national HIV prevalence appears to be declining with an estimated 0.36% in 2006 to 0.34% in 2007, this national statistic masks the more complex variation in state and district-level prevalence

throughout the south and north east. In fact, there are several states and districts where prevalence appears to be rising. A third of FSW sentinel sites have >5% prevalence, with the highest rates in Mumbai (42%) and Pune (59%). Similarly 50% of MSM sentinel sites have >5% prevalence.

USG Focus Groups	HIV Prevalence 2007
IDUs	7.2%
MSMs	7.4%
FSWs	5.1%
Migrants (defined as temporary change of residence)	3.6%
Truckers (defined as mobile populations)	2.5%
Antenatal Clinic Attendees	.48%
Pediatric	95,000 (based on public sector registration)
OVC	3-4 million (currently being estimated)

Source: HIV Sentinel Surveillance and estimation is conducted annually by NACO. The latest report available is HIV data 2007. The HIV Sentinel Surveillance data 2008 is expected by November 2009.

The USG is focused on five high burden areas: Tamil Nadu, Karnataka, Andhra Pradesh, Maharashtra and the North East region.

Distribution of PLWHA among high burden states:

	State	Percentage
1.	Andhra Pradesh	21%
2.	Maharashtra	20%
3.	Karnataka	11%
4.	West Bengal	10%
5.	Tamil Nadu	8%
6.	Gujarat	6%
7.	Uttar Pradesh	4%
8.	Rest of the states	20%

The GOI and USG Response

The GOI is now implementing the third phase of a $2.5 billion NACP-III, 2007-2012, a plan developed with input from the donor community, including critical support from the USG. This GOI strategy outlines a decentralized response to the epidemic to deliver expanded prevention, treatment and care services, with the goal of integrating HIV/AIDS services within the National Rural Health Mission (a national Primary Health Care (PHC) strategy reaching about two-thirds of India's population) by 2012. The integration of HIV/AIDS services will strengthen routine health and public health services in India.

NACP III has four primary objectives:

i. Prevent infections through saturation of coverage of high-risk groups with targeted interventions and scaled up interventions in the general population.
ii. Provide greater care, support and treatment to larger numbers of PLWHA.
iii. Strengthen the infrastructure, systems and human resources in prevention, care, support and treatment Program at district, state and national levels.
iv. Strengthen the nationwide strategic information management system.

With strong GOI leadership under the National AIDS Control Organization (NACO), and strategic USG support, there has been a swift roll-out of the third phase of NACP III, significantly increasing India's response to the HIV epidemic. NACP III outlines an ambitious time-line to deliver large-scale outcomes. For example, NACP III has set targets to scale-up prevention interventions at over 2,000 sites MARPs across 31 states; antiretroviral therapy (ART) in more than 200 centers; and the provision of counseling and testing (CT) services in nearly 5,000 centers.

The USG has a vital role to play supporting NACO's implementation of large-scale, multi-faceted HIV/AIDS program. Leveraging relatively modest resources, $30 million annually, in FY 2010 the USG will continue to meet NACO's critical need for technical assistance and capacity building at the national and state levels in select priority regions primarily: Tamil Nadu, Maharashtra, Andhra Pradesh, Karnataka and the North East (in Nagaland and Manipur). Transitioning to targeted technical assistance, the USG has dramatically reduced the number of districts receiving direct service provision. For example in Tamil Nadu the USG moved from working in 23 to 7 districts. The planned transition has allowed the GOI at all levels to support and maintain those services previously supplied by the USG. In line with NACP III and PEPFAR priorities, the USG will continue to increase the amount of TA through a mix of technical expertise and capacity building for NACO and State AIDS Control Society (SACS) to manage MARP interventions, care and support demonstration projects, OVC programming, laboratory strengthening and strategic information (SI) support. PEPFAR/India has established good working relations with each of the SACS in the focus states, and has supported effective partners on the ground.

USG efforts have recently resulted in a number of sustainable HIV/AIDS prevention, counseling and testing, treatment and SI programs. Maintaining a focus on sustainability, PEPFAR/India has established a four pillar approach including: capacity building at all levels of government; an ambitious transition from direct services to technical assistance, demonstration or pilot programs to test effective interventions and private sector expansion to guide India's NACP III. In FY 2010, PEPFAR/India will develop an innovative four-year HIV/AIDS Partnership Framework to better support the TA needs of a reinvigorated national program currently implemented with strong national leadership and formidable resources to carry out its mandate to reverse the HIV/AIDS epidemic in India.

Program Areas: Strengths, Weaknesses and Opportunities:

Program Area: Prevention: PMTCT/Sexual Prevention/ Biomedical Prevention/ Testing and Counseling

The NACO has a well-articulated, decentralized strategy. Dedicated HIV/AIDS efforts have led to a platform of data to support evidence based programming. Continued emphasis on prevention with set targets for saturating coverage of MARPs has maintained the momentum of HIV/AIDS efforts throughout the country. India has high quality behavioral and sentinel surveillance data on MARPs. In addition, migration patterns and MARPs hot spots have been mapped throughout the country to promote prevention and effective treatment programs.

In FY 2010 the USG will continue to be a primary source of TA and capacity building at all levels of the Indian government. At NACO's request the USG has established a critical mechanism for on-going technical support that is the Technical Support Units (TSU) to strengthen the capacity of SACS, with a priority on strengthening Targeted Interventions (TIs) for MARPs. NACO's annual evaluation of the TSUs revealed that the seven USG-supported TSUs were among the better-performing TSUs in terms of scaling-up and monitoring activities. These temporary TSUs are an excellent conduit to provide state level technical assistance and capacity building. Next year, the USG will continue to work to promote evidence based planning at the state and district levels to promote strategic MARPs interventions.

USG support has led to the GOI's adoption of a number of policies, protocols and demonstration models.

USG programs have pioneered prevention interventions among rural MARPs which have been adopted by NACO. For example, USG programs have successfully demonstrated sexual prevention interventions in selected sites which have resulted in scaling-up coverage, improving quality and beginning to stabilize the epidemic. Current interventions with MARP primarily focus on condom promotion. The provision of comprehensive package of services, including positive-prevention counselling, reduction of the number of sexual partners, increased access to STI treatment, HIV counselling and testing, care, support and treatment services, is being piloted by PEPFAR/India. USG programs have demonstrated systems for NGOs/Community Based Organizations (CBO) identification, capacity building and monitoring which are now replicated by SACS and NACO. In addition, the Ministry of Labor and Employment has endorsed a nationwide HIV/AIDS workplace policy based on over 400 workplace programs throughout the country.

India is actively expanding counseling and testing (CT) and PMTCT services. NACP III significantly scaled-up CT services by establishing 6,300 centers across the country and plans to expand to 10,200 centers by 2015. The increase CT service coverage specifically targets MARPs. To reach this goal, NACO is supporting CT services placed in the private sector and initiating demand generation programs to increase the uptake of services. The USG will continue to support NACO in scaling up and rolling out the effective implementation of comprehensive package of services in both the public and private sectors. At the Government of India's request, in FY 2010 there will be a special focus on Andra Pradesh as interventions have yet to penetrate the HIV epidemic in many districts in that state.

Rapid scale-up of CT services was not complemented by comprehensive, MARPs tailored demand generation programs to increase the uptake of services. Stigma, inconsistent quality, and limited private sector regulation/collaboration have impeded the full scale-up and utilization of MARPs services and support. Solid demonstration of community-based and private sector approaches will inform focus states enhancing MARPs counseling, testing and treatment. In FY 2010 USG will provide technical support in developing demand generation campaigns for increasing uptake of CT services among MARPs; developing operation research studies on community led CT approaches and addressing gender concerns in CT programs.

The most recent data from 2008 reveals that 4.15 million pregnant women (15.3% of all pregnancies) received PMTCT services and 19,986 tested HIV positive. However, of the identified positive pregnant women, only 51% of the mother-baby pairs received Single Dose Nevirapine (SD NVP). Unfortunately, many HIV positive pregnant women remain unidentified and similar to the Maternal Child Health (MCH) sector, poor care seeking behavior and low hospital utilization remain significant barriers to reaching pregnant women. Even when women are identified, there is a major service gap in follow-up with positive pregnant women after delivery. In addition, there is no male involvement in PMTCT services. In the next year PEPFAR/India will explore the possibility of completing a gender analysis examining the role men have in promoting PMTCT. Significant support from the Global Fund, Round 2, is supporting both PMTCT and ART treatment scale-up in public and private sectors. Considering that almost 50% of total institutional deliveries take place in private hospitals, collaboration with the private sector will significantly expand the GOI's out-reach to positive pregnant women and families. In FY 2010 USAID will continue support to three private sector PMTCT sites to explore opportunities for NACO. NACO and the USG will promote integrating HIV/AIDS into MCH services which would improve NACO's ability to reach and support positive pregnant women and their families.

The GOI is scaling up Oral Substitution Therapy (OST) to IDUs resulting in the accreditation of 27 OST centers. Strong coordination between NACO and the Ministry of Social Justice and Empowerment has resulted in 200+ NGO managed counseling de-addiction and rehabilitation centers. However, with the exception of the North East region, most SACS have not considered IDU interventions as a priority mainly due to their limited capabilities to address IDU needs. Furthermore providing comprehensive services to female IDUs is even more challenging. The USG will continue to support improved IDU HIV/AIDS programs in NACO and SACS through TSUs and focus on bringing international and regional experts to

develop more responsive IDU programs.

Program Area: Treatment: Adult/ Pediatric and Lab Infrastructure
National Government commitment for scale-up and support from GF Rounds four and six, have resulted in greater access to treatment and support services for both adults and children infected with HIV. NACO launched the free public ART program in April, 2004 in eight government hospitals located in six high HIV prevalence states. Today services are provided in 217 fully functional ART Centers. ART Technical Guidelines for Adults (both first line and second line) were developed and distributed to all ART Centers. NACP III plans to provide free ART services to 300,000 adults through 250 ART centers and 650 Link ART centers by 2012. Link ART centers (LAC) have been established in existing health facilities at district and sub-district level to make the treatment services more accessible and facilitate delivery of ARVs to PLHIV. Currently 577,011 PLHIV are registered in 217 ART centers and 223,000 are on ARVs. Of the total PLIV on ARVs, 39% are female. Over 53,000 of HIV infected children have been registered in ART centers and 14,474 children are on ARVs (39% or ARV care is provided to girls). An estimated 40,000 PLHIV seek ART services from the private sector.

Patient compliance and ARV drug adherence is poor. Late stage initiation of ARVs, and therefore management of AIDS, is more difficult resulting in high morbidity and mortality. Only 50% of the PLHIV tested positive at Integrated Counseling and Testing Centers (ICTC) are successfully referred to and registered at the ART centers. Nearly 25% of PLHIV enrolled at the ART centers have a CD4 count of less than 50cells/cmm resulting in high mortality rates despite being on ARVs. The follow-up of pre-ART patients is poor with few PLHIV receiving cotrimoxazole (CTX) prophylaxes. Lack of availability of drugs for Opportunistic Infections (OI) at the ART centers hampers the timely treatment of infections. There are also low rates of drug adherence. The USG has focused on home based care and support with ARV with three pilots to improve future treatment efforts.

While MARP interventions are expanding, working with MARPs remains challenging. Only 53% of FSWs and 77% MSM are currently reached in India. There are inconsistent levels of quality of MARP interventions throughout the country. Limited documentation of success stories and best practices in prevention programs has limited the positive influences to developing high quality programs. Moreover the MARPs high risk behavioral characteristics are evolving. For example, recently the dynamics of sex work have moved from predominately street and hotel operations to more underground venues such as private houses and lodges. This rapidly changing environment further complicates efforts to reach MARPs.

In order to effectively reach MARPs our understanding of MARPs behavior, situation and specific needs to deepen. There is a gap in specific data on MARPs' access to counseling, testing, care, support and treatment services in India. Given the success of NGO/CBO prevention programs to reach evasive MARPs there is an opportunity to work through NGO/CBOs to connect MARPs to much needed services. The USG will work to address the gaps in our understanding of MARP interaction with services and establish better linkages between prevention programs and counseling and testing, care, support and treatment programs.

The USG leads the national efforts to strengthen the 13 National and 117 State Reference Laboratories to improve quality of diagnostics and testing. India has a well laid out laboratory infrastructure with one 1 Apex lab, the National AIDS Research Laboratory (NARI), 12 National Reference Laboratories (NRLs) and 117 State Reference Laboratories (SRLs). There are approximately 5000 ICTCs for service delivery and 150 CD4 Laboratories providing support to ART Centers. However there remains an overall lack of quality laboratory testing services in the State Reference Labs and ICTCs. India does not have an active laboratory regulatory body and current Laboratory Management Information Systems (LMIS) are immature. PEPFAR/India support contributed to strengthening of the laboratories of the Indian Armed Forces Medical Services (AFMS). The USG-supported state-of-the-art laboratory at the Government

Hospital for Thoracic Medicine at Tambaram (GHTM), Chennai is recognized as one of the centers of excellence (COE) by NACO.

Recently the NRLs have been assessed and NACO is working to accredit these labs by a government recognized body, i.e., the National Accreditation Board of Laboratories, Dept of Science and Technology Government of India. CDC will continue to work with NACO strengthening SRL performance through assessments, feedback and technical assistance on laboratory management. A major objective of the laboratory strengthening efforts is to have all national and state reference laboratories accredited by the National Accreditation Board of Laboratories. A mature LMIS will be supported to facilitate quality systems. Finally rolling out rolling out of early infant diagnosis (EID) has major implications for the follow-up and treatment of positive women and their infants at the earliest stages.

Program Area: Care: TB/HIV and OVC
In 2009, USG PEPFAR supported a demonstration project providing mobile counseling and testing vans in remote rural areas for follow up of Direct Observes Therapy, Short Course (DOTS) treatment for co-infected persons. Counselors from various USG-supported projects have supported government DOTS centers to ensure smooth referrals and counseling of TB-HIV patients. The USG also developed the capacity of a wide range of health providers in HIV programs, including counselors, peer educators, HIV-positive network persons and men who have sex with men, to serve as DOTS providers.

The USG provided technical assistance to revise the TB-HIV providers' curriculum to improve treatment in both national programs. The USG-supported WHO technical advisor provides critical policy and technical inputs on TB-HIV issues at the national level. This advisor has worked closely with the GOI on policy development and program implementation, especially in the areas of TB/HIV surveillance, provider-initiated counseling and testing, and TB/HIV coordination. The USG, along with DFID, World Bank and WHO were involved in a series of Joint Monitoring Missions (JMM) to review progress in the implementation of the India Revised National Tuberculosis Control Program (RNTCP) and TB-HIV collaborative initiatives.

USG PEPFAR has worked with the USAID TB Control activities in Karnataka to strengthen the TB-HIV referral complex to ensure treatment adherence for both TB and ART through a comprehensive care, support and treatment program in 15 districts. Similar efforts are ongoing in five coastal districts of AP as well.

USG advocacy efforts for a stronger focus on OVC have resulted in the adoption of a national policy to support OVC treatment, care, and support. In addition, a national pilot to field-test new operational guidelines developed by the USG has been approved. However OVC implementation has been delayed due to a lack of true government commitment to OVC. In FY2010 the USG will continue to promote NACO efforts to support OVC and advocate for program implementation.

Other: Strategic Information/ Health Systems Strengthening/ Human Resources for Health and Gender
Strengthening SI systems is one of the four overarching objectives under NACP III, revealing NACO's commitment to improving SI systems, data collection and utilization to inform and effectively combat HIV in India. NACP III lays out a robust M&E framework along with performance measures, and benchmarks (annual core indicators and dashboard indicators) are reviewed every six months.
Currently multiple Management Information Systems generate program data. There is a program to integrate these systems into a Strategic Information Management System (SIMS) to form one comprehensive data reservoir.

However, there is no single national SI body to oversee the utilization of data for program enhancement, due, in part, to the limited SI capacities at all levels of government. While data are generated, usage is

still limited. In addition, poor data quality plagues the SI system. High staff attrition rates further complicate the SI objective, making it difficult to maintain a trained workforce.

The NACP III Midterm Review (MTR) will be a key SI driver, as it will encompass several important SI studies, including: Behavioral Sentinel Surveillance among MARPS; triangulation and validation of different data sets to identify hotspots that need renewed attention; and expenditure and resource allocation analysis. Results from these studies will be vital for a mid-course correction re-invigorating SI in the latter half of NACP III implementation. The process is already increasing interest in using available data. A well-functioning Strategic Information Management System at the state and national level will bring financial and programmatic data under the same umbrella to promote data for effective and efficient program implementation.

Presently, the health budget of state and central government combined to support clinical delivery of care is very low, at less than one percent of India's GDP. With the decentralization of health services, states now manage their programs, and they contribute approximately 80% to public health expenditures. In the states with low per capita incomes and with a high concentration of poverty, per capita public expenditure on health and family welfare remains very low.

The USG has a well respected track record of providing critical technical assistance and capacity development to support NACO, SACS, the Ministry of Labor and Employment and the Indian Armed Forces Medical Services' individual and institutional capacity development. In the coming years, the USG will focus on promoting convergence and integration with other sectors such as MCH, reproductive health (RH) and Primary Health Care (PHC) system strengthening. There are also opportunities for Public Private Partnerships that will be pursued by the USG in the coming years, while district level institutional strengthening will enable better outreach and interventions for MARPs.

The USG has taken the lead in supporting Health System Strengthening (HSS) initiatives to carry out NACP III in a wide range of program areas including: lab strengthening, human resource development, institutional capacity building of state and national governments. In particular the USG has emphasized neglected areas such as: communications, strategic information skills and systems, program management, prevention, and work with OVC. Efforts in HSS and Human Resource Health (HRH) have been scaled up with PEPFAR's mandate to transition to targeted technical assistance to enhance the scale-up and impact of NACP III.

Central to the USG led mentoring and human capacity development for NACO and SACS is government ownership. This has resulted in an intensive capacity building plan built into the NACP III program, such as the temporary TSUs shadowing SACS, and national and state reference lab initiatives promoting quality and performance monitoring systems.

While intense USG supported HSS and HRH initiatives are underway, there are challenges to effectively implement plans to improve HIV/AIDS competencies. Current barriers include: frequent changes in leadership of SACS project directors; poor quality of services due to the rapid service scale-up; duplication between functions and functionaries of the rural PHC system (NRHM) and NACO; the absence of a solid integration plan to promote high-impact HIV/AIDS outcomes; lack of a phase-out plan in place for temporary TSUs; lack of technically competent professionals in key NACO and SACS positions; absence of a coordinated, data driven system to identify the specific training needs of various cadres of HIV/AIDS program and service staff; and inadequate donor coordination with local institutions to develop and implement training programs.

Women living with HIV face special challenges in accessing services since they may not be able to leave their villages to seek treatment due to routine family responsibilities or care-giving responsibilities. The cross cutting issue of gender will be addressed by the USG in all program areas. While it is part of the

NACP III, gender is not a prevailing priority therefore the USG will continue to support deeper gender analysis, data collection disaggregated by sex and incorporating gender considerations in all aspects of NACP III implementation. It is well documented that considering gender will enhance program impact.

Integration of gender into USG programming increased since the last COP, but is still in the early formative stage. The recently formed USG Gender Technical Working Group (TWG) focuses on ensuring the India/USG team and partners address gender issues and that both PEPFAR and NACO gender guidelines are integrated and used in all the supported programs. In FY 2010 the TWG will be the focal point for addressing gender programming in HIV and mainstreaming gender with other programs. TA at the state, district levels and below, through partners and the USG supported TSUs in six states, includes addressing gender inequities in care, treatment, and prevention services, and reducing vulnerability and risk for MARPs and women.

FSW, MSM, and transgendered are highly vulnerable to both HIV and sexual violence. The risk of violence for young men and women is linked to early socialization of gender norms that implicitly sanction this mode of social control. USG partners are actively involved in group education interventions to promote more equitable gender norms and these activities will continue in FY2010.
In FY2010 USG partners will work to ensure that HIV-positive women have access to rights and entitlements. The USG will work with several state and district level PLHA networks and legal coalitions, such as the Women's Lawyers' Collective, to address the concerns of HIV-positive women. Referral systems will be strengthened so that health care providers will refer women to legal services to ensure property inheritance, widows' pensions, housing, and ration cards.

Since male risk behaviors are the single most important driver of the epidemic in India, shifting social norms for acceptable male behavior is critical to the success and sustainability of HIV prevention efforts. USG partners support such normative change through targeted interventions promoting mutual fidelity and partner reduction, and consistent condom use with non-regular partners. In four states, risk reduction interventions will continue to target short-term male migrants in urban areas. These interventions also protect their spouses, who often remain in their home villages. The USG-funded Positive Prevention Counseling Toolkit seeks to reduce risk behavior among HIV-positive men.

Sustainability Benchmarks
Targeted USG support, coupled with strong NACO leadership and significant NACP III resources, has fostered many sustainable achievements, especially: successful pilot or demonstration site scale-up, better functioning government bodies at the national, state and district levels and private sector engagement to expand HIV/AIDS efforts. In addition to the examples of sustainability already mentioned, a few highlights include:

GOI Adoption of USG Demonstration Site Projects:
NACO has scaled-up many USG supported implementation models developed in demonstration sites or pilot programs.

- The USG's model program piloting task-shifting through the nurse-practitioners (NP) expanded to 266 facilities.
- Several USG MARPs interventions, such as work with trucker and migrant populations, are now completely supported by state governments.
- USG efforts in Tamil Nadu (TN) such as Women's Self-Help Groups (SHG) and Youth Red Ribbon Clubs (RRC) are now funded and maintained by the TN state government.
- In Karnataka, USG partners pioneered the concept of reaching rural MARPs through Link Workers, a model now recognized by NACO and scaled-up nationally through the support of the GFATM.

- Communication materials developed by USG partners for MARPs and bridge populations have also been adopted and disseminated by SACS and NACO.
- An assessment tool for prioritizing industries based on risk developed by a USG partner in Andhra Pradesh is now being used by other agencies.
- The Ministry of Labor and Employment is about to launch a nationwide HIV/AIDS workplace policy developed by the USG based on work in over 400 workplace programs throughout the country.
- The Indian Armed Forces now fully maintains and properly utilizes laboratories with appropriate equipment to diagnose, treat and support military personnel and their families infected and affected by the HIV epidemic.

Better functioning government bodies at the National, State and District levels:

- Since late 2007, NACO led a Joint Implementation Review (JIR) every six months. The JIR is a self-governed, multi-sectoral review involving NACO, SACS, donors, and local experts. NACO and SACS receive strategic recommendations from the JIR to improve their HIV/AIDS programs.
- The newly formed TSUs are a team of professionals assisting SACS with strategic planning, capacity building, targeted interventions, public-private partnerships (PPP) and mainstreaming HIV/AIDS priorities with non-health ministries. With the TSUs in place SACS increased program management capacity. For example, many SACS are now, for the first time, preparing evidence-based annual action plans that are expanding the scale and quality of state programs. Some HIV/AIDS program state expenditures have almost doubled in the last year. In Uttar Pradesh, the SACS increased tailored MARPS interventions from about 55 to over 100 specific interventions.
- With USG support a number of government bodies have either been developed or reinvigorated to address HIV/AIDS through NACP III. These include:
    - District AIDS Prevention and Control Units (the nodal agency for implementation and monitoring of HIV programs and services at district level)
    - State Training Resource Centers (local institutions such as academic universities and medical colleges identified as the state-level nodal agency responsible for training and capacity building activities related to HIV prevention programs for MARPs)
    - The National Institute of Biology (the equivalent of U.S. National Institutes of Health – to support state of the art diagnostics)
    - The National Centers for Disease Control (the newly designated institute modeled on the USG CDC)
    - The Indian Network of Positive Persons (actively engaging in innovative positive prevention approaches)
- USG TA for communication at NACO and SACS built strategic health communication leadership and facilitated NACO's development of thematic communication strategies tailored to specific populations.

Private Sector Expansion:

- The USG initiated India's first private sector insurance scheme for PLHIVs. This privately financed insurance scheme is attracting a number of insurance companies that previously excluded HIV positive clients from their insurance plans. This ground breaking initiative has tremendous potential to facilitate PLHIVs' access to quality care and support services while also reducing the financial burden for families and communities affected by the epidemic.
- A help-line for PLHIVs was launched with USG support and significant support from Tata, a major Indian corporation. Now the GOI is also supporting Tata to scale-up this highly utilized communication tool to additional states.
- USG support for innovative work place policy programs has resulted in active work place programs financed and maintained by over 200 companies throughout the country.

- NACO signed a Memorandum of Understanding (MOU) with leading private sector companies /business corporations (Bajaj, Reliance and Godrej) to establish ten ART Centers in the private sector to provide treatment to more than 3,000 PLHIV.

These are exciting, sustainable achievements that go beyond direct service delivery to the more complex and intensive efforts of fostering the systems and government commitment to implement and maintain proven HIV/AIDS models well after USG support has graduated.

Confirmation of GOI Commitment to HIV/AIDS
Over the last year there have been several important developments indicative of the GOI's commitment to combating HIV/AIDS in India:

a) The historic judgement by the Delhi High Court legalising consensual adult male homosexual relations and overturning the Indian Penal Code Section 377. This change in the legal code is widely seen as an important step to create a more enabling environment for programs seeking to reach marginalized MSM with HIV services.

b) Multiple bi-lateral and multi-lateral donors have been invited to participate in an intensive Mid-Term Review (MTR) of NACP III programs. The MTR will assess the progress of NACP-III against plans; provide insight on factors facilitating/hindering progress; ascertain the effectiveness of technical strategies; and review resource commitments and gaps. The MTR reveals the GOI's true commitment to transparency, program effectiveness and collaboration to improve its already well functioning national program.

c) Nationally 1,513 TI projects were implemented, an increase of almost 80% from last year. NACO also rolled-out the Link Worker Program in 90 out of 187 high HIV prevalence districts to ensure TIs reach rural MARPs. USG prime partners in Tamil Nadu and Maharashtra have leveraged resources from NACO to implement the Link Worker Program in their high-prevalence districts.

With the implementation of NACP III and the strong leadership of NACO, India now has a well functioning vertical program that has rapidly advanced India's response to HIV/AIDS. This year it became increasingly evident that a major boundary to NACP III progress is the serious stigma and discrimination against PLHIVs and the poor integration of HIV/AIDS programs with other services, manifesting in a general inability to effectively reach MARPS with services and support. NACP III introduced a decentralization plan transferring services and oversight to the states. While the decentralization will help integration of services in the long term and routinizing HIV/AIDS services may decrease stigma, in the short term it has revealed poor capacity by the SACS to use data or resources to efficiently execute MARPs focused programs.

In FY 2010
The USG will continue to play a critical role in India's fight against HIV/AIDS as the GOI continues to provide a strong leadership and commitment to addressing the enormous challenges of the HIV/AIDS epidemic in the world's largest democracy. The PEPFAR/India program has closely aligned with the national program, established good working relations with each of the SACS in the focus regions, and supported effective partners on the ground. The long-term focus of USG is on strategic provision of TA and strengthening the quality of service delivery through strategic partnerships that leverage public and private resources. This will be pivotal year for the USG to promote innovative MARPS interventions, support the fight against stigma, and capitalize on opportunities for integration and continued capacity building at all levels of government. President Obama's Global Health Initiative will open up new opportunities for PEPFAR to promote HIV/AIDS integration in MCH, RH and HSS initiatives accelerating India's progress in combating HIV.

Annex I:
Relevant demographic and HIV/AIDS data:

Population Groups	Population Size	Source of Data	Year of Estimate
Total population (all ages)	1028610000	Census	2001
Women 60 years & above	38,853,994	Census	2001
Women 15 -59 years	282,238,162	Census	2001
Men 60 years & above	37,768,327	Census	2001
Men 15 -59 years	303,400,561	Census	2001
Girls 0 – 14 years	174,123,490	Census	2001
Boys 0 – 14 years	189,487,322	Census	2001
Age not stated	2,738,472	Census	2001

Note: Census of India data is published by Office of Registrar General of India, Govt of India, Ministry of Home Affairs. The last Census was conducted in 2001. The next census is planned in 2010.

Health Indicators:

- Life expectancy at birth : 68years
- Infant mortality 57/1000 (NFHS 2006)
- Peri-natal mortality 49/1000 (NFHS 2006)
- Maternal mortality ratio : 300/100,000 (SRS 2007)
- Percentage of safe deliveries : 47%
- Percentage of underweight children: 43%
- Birth rate 23.1/1000 (SRS 2008)
- Crude death rate ; 7.4/1000 (SRS 2008)
- Total Fertility rate :2.7

Socio Economic indicators:

- Adult Literacy (Male) : 78% (NFHS 2005- 2006)
- Adult Literacy (Female): 55% (NFHS 2005-2006)
- Human Development Index : 0.62 (Human Development Report 2008)
- Access to an improved water source (rural) : 82% (World Bank 2005)
- Access to improved water source (urban) : 96% (WB 2005)
- Access to improved sanitation facilities (rural): 18% (WB 2005)
- Access to improved sanitation facilities(urban): 58% (WB 2005)
- Unemployment rate : 7.2% (2008)
- Percentage of women employed :43%
- Percentage of men employed :87%

- Median age at marriage : 17.2 years (NFHS 2006)

Population Groups	Estimated Number	Source of Data	Year of Estimate
Number of people living with the disease *(all ages)*	2,310,000	HIV Sentinel Surveillance and HIV Estimation 2007: A Technical Brief (Annex 22)	2007
Injecting drug users/ HIV +	156,300 Estimates may be revised based on Mapping of HRG carried out in 2008-09. 7.2% HIV positive (2007 HSS)	Report of Expert Group on size estimation of population with high risk behavior for NACP-III Planning	2004
Sex workers/ HIV +	1,250,114 5.1% positive (2007 HSS)	- same as above -	2004
Men who have sex with men/ HIV +	2,352,135 7.4% positive (2007 HSS)	- same as above -	2004
Truckers	0.3 million	- same as above -	2004
Migrants	8.64 million	- same as above -	2004
HIV+ Pregnant women	65,000	GF Round 2	2008
People co-infected with HIV/TB estimated	65,000	CTD/NACO	2008

Drafter:
Kimberly Waller, PEPFAR Coordinator, x8393

Population and HIV Statistics

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV						
Adults 15-49 HIV Prevalence Rate						

Children 0-14 living with HIV						
Deaths due to HIV/AIDS						
Estimated new HIV infections among adults						
Estimated new HIV infections among adults and children						
Estimated number of pregnant women in the last 12 months						
Estimated number of pregnant women living with HIV needing ART for PMTCT						
Number of people living with HIV/AIDS						
Orphans 0-17 due to HIV/AIDS						
The estimated number of adults and children with advanced HIV infection (in need of ART)						
Women 15+ living with HIV						

Partnership Framework (PF)/Strategy - Goals and Objectives

(No data provided.)

Engagement with Global Fund, Multilateral Organizations, and Host Government Agencies

Redacted

Public-Private Partnership(s)

Partnership	Related Mechanism	Private-Sector Partner(s)	PEPFAR USD Planned Funds	Private-Sector USD Planned Funds	PPP Description
Private Sector Partnerships for Health (PSP4H)	13642:Private Sector Partnership for Health (PSP4H)				PEPFAR/India has supported many PPPs with past COP funding, demonstrating innovative models that contributed to achieving HIV-related goals in India, and informed national dialogue on private sector engagement in the National AIDS Control Program (NACP). In FY 2012, PEPFAR/India will build on these successes to invest in a mechanism that will strengthen the Government of India's (GOI) capacity to identify, attract and manage PPPs. The objectives of this project – Private

					Sector Partnerships for Health (PSP4H) – are to: (1) strengthen the stewardship role of National AIDS Control Organization (NACO) and State AIDS Control Societies to foster and monitor PPPs in the NACP; (2) strengthen evidence on impact of PPPs on HIV outcomes; and (3) demonstrate scalable PPP models for improved access to quality and affordable HIV services. PSP4H will also support the GOI to establish a platform within NACO for enabling, identifying and managing future PPPs that support achievement of NACP goals.

Surveillance and Survey Activities

Name	Type of Activity	Target Population	Stage
Adult and Pediatric Case Reporting - not	AIDS/HIV Case	Pregnant Women	Other

PEPFAR funded	Surveillance		
ANC Sentinel Surveillance/PMTCT	Sentinel Surveillance (e.g. ANC Surveys)	Pregnant Women	Implementation
Behavioral Surveillance	Behavioral Surveillance among MARPS	Drug Users, Female Commercial Sex Workers, Injecting Drug Users, Male Commercial Sex Workers, Men who have Sex with Men	Planning
HIV Drug Resistance Surveillance - not PEPFAR funded	HIV Drug Resistance	Other	Planning
HIV Incidence	Other	Injecting Drug Users, Migrant Workers, Men who have Sex with Men	Planning
India Demographic and Health Survey	Population-based Behavioral Surveys	General Population, Injecting Drug Users	Planning
Pediatric Surveillance - not PEPFAR funded	Other	Other	Implementation
Population size estimation	Population size estimates	Injecting Drug Users, Migrant Workers, Mobile Populations, Men who have Sex with Men, Other	Other
TB/HIV Surveillance - not PEPFAR funded	TB/HIV Co-Surveillance	Other	Implementation

Budget Summary Reports

Summary of Planned Funding by Agency and Funding Source

Agency	Funding Source				Total
	Central GHCS (State)	GAP	GHCS (State)	GHCS (USAID)	
DOD			608,467		**608,467**
DOL			294,667		**294,667**
HHS/CDC		3,000,000	3,054,423		**6,054,423**
HHS/HRSA			1,100,000		**1,100,000**
USAID			942,443	21,000,000	**21,942,443**
Total	**0**	**3,000,000**	**6,000,000**	**21,000,000**	**30,000,000**

Summary of Planned Funding by Budget Code and Agency

Budget Code	Agency						Total
	DOD	HHS/CDC	HHS/HRSA	DOL	USAID	AllOther	
HBHC	32,500	310,000	325,000		1,736,649		**2,404,149**
HKID					1,168,116		**1,168,116**
HLAB	40,000	420,000					**460,000**
HTXS	67,500		400,000		246,011		**713,511**
HVAB	70,000	25,000			489,362		**584,362**
HVCT	249,500				1,022,214		**1,271,714**
HVMS	26,272	2,854,423			1,325,000		**4,205,695**
HVOP	105,000				3,800,617		**3,905,617**
HVSI	17,695	1,000,000	35,000		2,464,988		**3,517,683**
HVTB			90,000		25,000		**115,000**
IDUP					69,000		**69,000**
MTCT					675,351		**675,351**
OHSS		1,445,000	206,000	294,667	8,752,118		**10,697,785**
PDCS			22,000		168,017		**190,017**
PDTX			22,000				**22,000**

	608,467	**6,054,423**	**1,100,000**	**294,667**	**21,942,443**	**0**	**30,000,000**

Budgetary Requirements Worksheet

(No data provided.)

National Level Indicators

National Level Indicators and Targets

REDACTED

Policy Tracking Table

(No data provided.)

Technical Areas

Technical Area Summary

Technical Area: Adult Care and Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
HBHC	2,404,149	
HTXS	713,511	
Total Technical Area Planned Funding:	**3,117,660**	**0**

Summary:
Context and Background The National AIDS Control Organization (NACO) is the lead agency addressing the challenge of providing HIV/AIDS treatment, care and support for the estimated 2.31 million people living with HIV/AIDS in India. Currently over 223,000 People Living with HIV/AIDS (PLHIV) are receiving antiretroviral therapy (ART) from 217 ART centers located through out the 31 states/union territories. An estimated 40,000 PLHIV seek ART services from the private sector. NACO launched the free public ART program in April 2004 in eight government hospitals located in six high HIV prevalence states. Today services are provided in 217 fully functional ART Centers. ART Technical Guidelines for Adults (both first line and second line) were developed and distributed to all ART Centers. The Third National AIDS Control Program (NACP III) targets provision of free ART services to 300,000 adults through 250 ART centers and 650 Link ART centers by 2012. Link ART centers (LAC) have been established in existing health facilities at district and sub-district level to make the treatment services more accessible and facilitate delivery of ARVs to PLHIV. The primary role of these centers is enrollment of PLHIV in HIV care, basic investigation and management in pre-ART patient and ARV drug dispensing for stable patients on ARVs. Currently 116 LAC are functional, each serving a minimum of 10 patients on ART (five in hilly areas) or 50 PLHIVs identified through Integrated Counseling and Testing Centers (ICTC). The national guidelines for pre-ART management of PLHIV include comprehensive medical history and physical examination, baseline laboratory tests and follow-up, nutrition and antiretroviral counseling, visits for Pre-ART Care and CD4 screening. Cotrimoxazole (CTX) prophylaxis is initiated at CD4 count less than 350 cells/cmm. The first line recommended ART regimen is either Zidovudine/Lamuvidine/Nevirapine or Stavudine/Lamuvidine/Nevirapine, taken twice daily (BID) as a fixed dose combination (FDC). The Revised ART Guidelines specify ART initiation at a CD4 count of 250 cells/cmm. CD4 testing is available in 152 Centers. CD4 kits are procured centrally and supplied to all facilities based on need. NACO bulk supply of drugs and CD4 kits reduced the annual first line antiretroviral drug cost to US$120/person and CD4 count test to US$4/test. The ARV drugs are procured by NACO with Global Fund resources. First line and second line ARVs are available in the national program. Monitoring for the drugs is done centrally based on the monthly consumption and stocks at the ART centers. It is ensured that all ART centers have a minimum of three months stock of drugs. The supply chain management of ARV drugs is done by the National Logistic Coordinator at NACO. A monthly computerized reporting system from ART Centers to NACO and State AIDS Control Societies (SACS) is in place to improve adherence to treatment and reduce drop-out rates The cumulative lost to follow up was reduced to 8% (2008) from 15 %(2006). The 11 center WHO Cohort study of 8,508 patients who started on ART spread across the country has revealed that 80% of the adults initiated on ART are alive and on ART (12 months after initiation). An estimated 3,000 patients (2-3%) may be in need of second line ART due to treatment failure. Viral load testing is not widely available, limiting the

ability to accurately identify PLHIVs failing first-line therapy. Currently, only 354 patients receive second line drugs at 10 centers. NACO established over 250 Community Care Centers (CCCs) in NGO/FBO-run inpatient care facilities in over 100 districts. The CCCs are facility based, primary care institutions, which play a critical role in providing treatment for Opportunistic Infections, care and support services to PLHIV. The CCCs is linked with ART Centers and ensure counseling and social support services. The national operational guidelines for CCC have been developed and are bei ng implemented at the state and district level. NACO signed a Memorandum of Understanding (MOU) with leading private sector companies /business corporations (Bajaj, Reliance and Godrej) to establish ten ART Centers in the private sector to provide treatment to more than 3,000 PLHIV. NACO has partnered with Confederation of Indian Industries (CII) and other corporate sectors on workplace intervention. NACO works closely with its intersectoral partners like Railways, Employees State Insurance department, paramilitary forces and key NGOs for care support and treatment services. Some of the key challenges in the care and treatment services are that only 50% of the PLHIV tested positive at the integrated counseling and testing centers (ICTC) are being referred to and registered at the ART centers. Nearly 25% of PLHIV that are enrolled at the ART centers have a CD4 count of less than 50cells/cmm resulting in high mortality rates despite being on ARVs. The follow up of pre-ART patients is poor with very few PLHIV receiving CTX prophylaxis; non availability of drugs for Opportunistic Infections at the ART centers hampers the timely treatment of infections; low rates of drug adherence. Women living with HIV face special challenges in accessing services since they may not be able to leave their villages to seek treatment due to routine family responsibilities or care-giving responsibilities. Data on the use of care and treatment services by marginalized, most-at-risk populations (MARP) are limited but estimated to be less than 10% of the total service burden. Accomplishments since last COP The USG played a key role as an active member of the Care and Treatment Technical Working Group at national level, providing technical expertise for revising the ARV initiation guidelines. The revised eligibility criteria for ARV initiation is now at a CD4 Count of less than 250 cells/cmm instead of 200 cells/cmm. At the Government Hospital for Thoracic Medicine (GHTM) in the state of Tamil Nadu (TN), the USG established an ART outpatient center; state-of-the-art laboratory; training center; computerized patient information system; counseling center for couples and families, staff trainings and leadership development; and a hands-on fellowship in HIV/AIDS clinical medicine and leadership for 14 young physicians per year. This effort led to GHTM being labeled as one of 10 Centers of Excellence (COE) in HIV by NACO. The USG supported a technical consultant to NACO to assess each of the new COE and develop a COE rollout plan. This consultant is providing support to NACO and SACS program staff to enhance their knowledge of HIV treatment and management of complicated Opportunistic Infections. The USG provided technical support to the Global Fund proposal Rolling Continuation Channel (RCC) Round 4&6. The key objective of this proposal is provision of Care, Support and Treatment services to PLHIV including children. NACO designated the USG as the lead coordinator for engaging the private sector in HIV/AIDS prevention, care and treatment. An HIV group insurance scheme for PLHIV was piloted in collaboration with Star Insurance. To date 1000 PLHIV are enrolled under this scheme with plans of additional scale up in all the USG priority states. _Hello Plus_ a dedicated toll-free helpline for PLHIV was launched by NACO, USG and the TATA Group of Companies with potential for scale-up. USG partners worked with the Indian Network of Positive People (INP+) and SACS to implement the Greater Involvement of People with AIDS (GIPA) concept in existing HIV care and treatment projects. The USG partners supported District Level Networks to strengthen involvement of PLHIV in positive prevention counseling. USG partners have referred and enrolled more than 7,000 PLHIV in the NACO designated ART centers. More than 40% of the PLHIV on treatment are women. USG partners have trained over 500 health care workers in ARV counseling and management of drug toxicity. USG FY 10 and FY11 Support In FY10, USG activities will focus on providing TA for adult care and treatment. The key TA areas include engagement of the private sector, establish demonstration models for ARV adherence through home and community based approaches and implementation of the CCC guidelines for care and support services. The USG will help NACO to develop an accreditation process for publicly funded ART to improve quality and standardization of services. The USG will plan training programs and workshops on ART focusing on operational and technical challenges. The USG will guide the expansion of the private sector engagement in care and treatment services at state and

district level. The USG will assist NACO in developing plans and in the selection of an institution to manage the network of private partners. The USG will also assist in developing a private sector advocacy package, capacity building, and M&E of care and treatment programs. These include ensuring quality ART in the private sector and strengthening linkage of vulnerable populations to ART services. The USG partners in TN, Karnataka and Maharashtra will have three demonstration sites for home-based care programming that will emphasize strong outreach and skills building programs to support PLHIV on treatment adherence, community engagement and a family centered care approach. The demonstration projects will support women and young girls in order to alleviate the burden of HIV/AIDS care which often falls disproportionately on women and young girls. The demonstration sites will also engage and support people living with HIV who are willing to act as peer supporters and treatment supporters to provide psychosocial support to people on ART. The skills to sustain adherence to lifelong treatment, protective behavior, positive prevention and reducing HIV/AIDS related stigma at the community level will be demonstrated at these specific sites. The Link Workers Program in the states of Maharashtra, TN and Karnataka will support the demonstration projects to mobilize vulnerable populations to utilize care and treatment services in 52 high prevalence districts across the states of Maharashtra, TN and Karnataka. Link workers will use the procedures determined in the USG demonstration projects to improve access to services by establishing linkages between ICTCs and ART centers. The link workers will also facilitate access to user friendly ART services for MARPs. Reaching out to HIV positive MARPs with positive prevention services is critical. The counseling and service needs for MARPs are different from the general PLHIVs . The USG will do an assessment of MARP _ PLHIVs and develop a comprehensive positive prevention program targeting MARP-PLHIVs. Existing modules will be adapted and NGOs and positive networks will be trained on positive prevention for MARPs. USG partners will strengthen the Andhra Pradesh AIDS Consortium (APAIDSCON) of 15 private medical colleges in Andhra Pradesh (AP) to expand access to and strengthen the quality of private sector care and treatment services. Similarly, the model center of training for the private sector at Perunderai Medical College in TN will be further strengthened. These will serve as models for private sector involvement through the network of identified private clinics in TN. Recognizing the fact that there are many gaps in current training programs for ARV adherence counseling and support services, USG partners will prioritize and support specific training programs at the state level to ensure improved quality of care and treatment services. The different cadre of healthcare providers will be identified in the public and NGO sectors and based on an analysis of their training needs, specific trainings will be conducted on comprehensive HIV care. Treatment literacy programs will include accurate, simple information about the names and types of medicines, how they work, managing side effects, dispelling myths and misconceptions about HIV and ART as well as s afer sex practices. Positive prevention will continue to be an area of focus for increasing the self-esteem, confidence and ability of HIV positive people to protect their own health and to avoid infecting others. It will be implemented within an ethical framework that respects the rights and needs of PLHIV to enjoy sexual relationships, have reproductive choices and live a full and healthy life.

Technical Area: Biomedical Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
IDUP	69,000	
Total Technical Area Planned Funding:	**69,000**	**0**

Summary:

Context and Background In the context of biomedical prevention, the Government of India (GOI), under Phase III of the National HIV/AIDS Control Program (NACP-III), addresses blood safety, injection safety, bio-medical waste management and interventions for injecting drug users (IDU). Male circumcision is not a priority for the national program due to long standing cultural sensitivities around that issue. The

USG_s engagement in biomedical prevention is limited to interventions for IDUs, biomedical waste management and to a lesser extent, injection safety. I. Injecting and Non-injecting Drug Users (NIDU) The HIV epidemic in India continues to be a concentrated epidemic with a national adult prevalence of 0.34%. Being one of the most populated countries in the world, India is home to an estimated 2.31 million people living with HIV. The prevalence among men is higher (0.40%) than in women (0.27%) and the overall prevalence varies among the core high risk groups like IDUs (7.2%); men who have sex with men (MSM) (7.4%); and female sex workers (FSW) (5.1%). National averages mask the large regional variations in HIV prevalence, as 60% of people living with HIV live in the four southern states of the country where the epidemic is largely attributable to risky sexual behavior. In the northeastern states, where the prevalence of HIV is increasing, the HIV epidemic is driven by unsafe sex and injecting drug use. Most-at-risk populations (MARP) exhibit higher HIV prevalence. HIV prevalence among IDUs is high at 7.2%, an increase from the 6.9% estimate in 2007. NACO estimates that there are new pockets of the epidemic among IDUs in the country. NACO estimates that nearly 73% of IDUs in the country are covered through current prevention interventions. Coordination with Other Programs NACO and State AIDS Control Societies (SACS) are the lead players in HIV interventions among IDUs. The Ministry of Social Justice and Empowerment (MSJE) also works with IDUs and supports 200 NGO-managed counseling, addiction and rehabilitation centers. NACO supports the counselors in these MSJE-supported centers. The United Nations Office of Drugs and Crime supports drug use assessments. The Bill and Melinda Gates Foundation and Australian Aid are engaged in supporting prevention interventions among IDUs. The IDU interventions in India focus primarily on harm reduction, condom promotion, needle/syringe exchange and HIV/AIDS and behavior change communication messages. Another important initiative of the government is its efforts to ensure quality delivery of Oral Substitution Therapy (OST). A total of 27 OST centers have been accredited and will cover about 3500 clients on OST. There are several challenges in the IDU intervention programs which need to be addressed as a priority. Saturating coverage of IDUs, advocacy with law enforcement agencies for an enabling environment, and addressing the regular partners and spouses of IDUs to reduce HIV transmission and vulnerability are some of the major issues. The possibility that other types of drug users will shift to injecting drug use is high but has not been addressed thus far by the Government of India or Tamil Nadu. II. Injection Safety and Biomedical waste management To serve the large population in India, the health care system has expanded significantly and progressed both scientifically and technologically, to meet the ever increasing demands. More than 50% of patients visiting a primary health care provider receive at least one injection at that visit. The GOI estimates that 800 million injections take place in health care facilities each year. Unsafe injections account for a proportion of the Hepatitis B, Hepatitis C, and HIV infections. Biomedical waste generated during diagnosis, treatment and immunization processes in healthcare establishments includes sharps, human tissue or body parts and other infectious material, which have the po tential to transmit various infectious agents (such as HIV and Hepatitis). Healthcare workers (HCW) are at particular risk of disease transmission via biomedical waste due to their repeated exposure to this potentially infectious material. In addition, biomedical waste that is improperly segregated and disposed of can contaminate non-infectious waste and thereby transmit disease to waste disposal personnel and others that may come in contact with it. There is very limited data on the amount of infections that occur via biomedical waste. With the increasing availability of care for people living with HIV/AIDS (PLHIV) in India through community care centers (CCC), ART and link-ART centers, biomedical waste management and infection control measures must be practiced by all HCWs, especially those involved in patient testing and treatment activities. NACP-III specifically recognizes the risks associated with biomedical waste disposal and is beginning to implement workplace safety programs. These include biomedical waste management and infection control measures to be practiced by HCW. Coordination with Other Programs NACO and SACS work in coordination with the Directorates of Medical Education, Public Health, and Medical Services in creating awareness and improving knowledge on safe injection practices, and in training Health Care Workers in safe and effective ways while providing services to PLHIV. Accomplishments since last COP: IDU: The USG_s engagement in IDU programs is focused on providing technical assistance to NACO including the development of statewide mapping of IDUs in Tamil Nadu, Kerala and Uttar Pradesh. In addition, the USG supports the development of IDU intervention

guidelines. USG engagement in direct implementation of IDU programs is focused on the state of Tamil Nadu, where HIV prevalence among IDUs is 16.8%. Also in TN, USG prime partners support eight targeted intervention (TI) projects through non-governmental organizations (NGO) and community-based organizations (CBO). The programs create HIV/AIDS awareness, promote condom use, treat STI patients, create demand for counseling and testing services and refer HIV-positive IDUs to care, support and treatment services. Safe needles and syringes are being sourced from the government and other agencies. More than 240 IDUs have been reached through USG programs in the last year. However, treatment coverage remains low, as there are an estimated 2,500 IDUs in the state. Additionally, the USG-supported Technical Support Unit (TSU) provides critical assistance to the SACS in identifying and building the capacity of NGO and CBO partners for IDU interventions in Tamil Nadu, Pondicherry and Kerala. In Tamil Nadu, a panel of consultants/experts has been formed to provide technical and programmatic inputs to partners involved in IDU interventions Injection Safety and Bio Medical Waste Management: The USG developed a training curriculum for nurses and other HCWs on infection control, waste management and waste disposal at health facilities. Twenty nurses from two organizations were trained using a _Training of Trainers_ model. These organizations in turn trained an additional 60 nurses. The curriculum has been shared with 20 local NGO organizations. USG FY10 and FY11 Support USG-supported TSUs will continue to provide technical assistance to the SACS for saturation of coverage of IDUs, quality assurance of IDU programs, coordination with MSJE for addiction programs, and strengthening the supply chain management system. Greater emphasis will be given to reaching out to the sexual partners of IDUs and to promote safe sexual practices. Expected Outcomes in FY2010: _ Provide technical assistance in mapping IDUs _ Documentation and dissemination of experience and challenges _ Provide TA specific to care, support and treatment services for identifying and building the capacity of partners for IDU interventions. _ Technical Support Units provide critical inputs in analysis of data and use for program planning _ Provide TA for training to HCWs in biomedical waste management IDU: The USG will continue to support the GOI in the prevention of HIV transmission via biomedical materials and waste. This will include the implementation and operation of the GOI_s Biomedical Waste Rules (2006) that were developed to provide health facilities with clear and practical guidelines for the appropriate handling and disposal of biomedical waste. Injection Safety and Bio Medical Waste Management: The USG will support implementing partners to build the capacity of HCWs to properly handle and dispose of biomedical waste. In FY2010, the USG will seek to collaborate with GOI partners to roll-out this training to HCWs in other facilities, including ART and Link ART centers, CCCs and the general health care services.

Technical Area: Counseling and Testing

Budget Code	Budget Code Planned Amount	On Hold Amount
HVCT	1,271,714	
Total Technical Area Planned Funding:	**1,271,714**	**0**

Summary:
Context and Background Despite substantial efforts to expand access to HIV counseling and testing (CT) services, only 20 to 25% of adult people living with HIV/AIDS (PLHIV) are aware of their status. Among this group, only 50% of their partners have been tested for HIV. The low uptake of CT limits the pace of scale-up as it relates to HIV care and treatment, for the estimated 2.31 million PLHIV, and limits opportunities for positive prevention and other support services that may help reduce risky behavior. India_s epidemic is concentrated. CT services are therefore targeted to most-at-risk-populations (MARPs) to ensure individuals know their HIV status and are able to access to HIV prevention, care and treatment services. However, according to National AIDS Control Organization (NACO) testing uptake among MARP was less than 10%. NACO is spearheading the CT program, specifically targeting MARPs

(includes clients of sex workers and bridge populations) in India. Program funding is provided by the Global Fund for AIDS, TB and Malaria (GFATM). The USG provides complementary technical assistance (TA) in CT to the national program. NACO set a goal of diagnosing 80% of the estimated PLHIV by 2015. Part of the strategy to reach this goal is to expand access to CT services to MARPs by establishing 10,700 CT centers and testing 115 million people. NACO provides CT services primarily through Integrated Counseling and Testing Centers (ICTC) located in the government health facilities such as District Hospitals and Community Health Centers (CHC) at sub-district level. Under the Third National AIDS Control Program (NACP III), all stand-alone CT and PMTCT Centers funded under GFATM Rounds 2, 3, and 6 were redesigned as ICTC. These centers provide CT and PMTCT services, TB screening and linkages to ART service at one facility. As part of the national strategy, 6,300 ICTCs are in operation across the country. NACO is laying strong emphasis on ensuring access to MARPs in high prevalence districts by making available CT services at the CHCs and 24-hour Primary Health Centers (PHCs). The The USG is developing models of referral linkages including mobile clinics for MARPs and assisting in scaling-up the lessons nationally. According to a NACO report, the number of people tested has increased from 4.3 million in 2006 to over 10 million in 2009. Despite significant expansion in availability of access to CT services, the coverage is still low (<25% of the infected population) in part due to concerns of stigma, fear of receiving an HIV positive test result, lack of confidentiality and poor quality of services. NACP III was designed to combine the gains of ICTC geographical expansion with integration across the health system. Provision of CT services in diverse settings would allow individual choice of access point, routine HIV testing, and decrease identification of a center with only HIV CT services. Key components are decentralization of HIV service provision and administration to the district level through integration with the general health services of the National Health Rural Mission (NRHM) and expansion into the private sector. By the end of 2015, CT services will be provided as part of the routine health services in 5,970 CHCs and PHCs. To further expand coverage and improve access to MARPs and vulnerable populations, 1,200 new ICTCs will be started in the private sector. MARP individuals may face additional legal and stigma issues related to their risk that limit access to CT services. A major concern identified by NACO is that MARPs do not access public-sector CT services. A multisite study showed significantly increased uptake by vulnerable populations of community-based HIV CT services compared to routine CT services. Based on this information, NACO instituted a comprehensive community mobilization strategy to increase the uptake of CT services among MARPs from 10% to 90% by 2015. The strategy includes the decentralization of CT services to district and NRHM, use of mobile clinics and implementation of the Link Workers Program (LWP). NACO will initiate mobile CT services in all high prevalence districts and place link workers in 187 high prevalence districts in the country to improve access to HIV CT for MARPs in rural areas. The USG will complement NACO_s efforts by demonstrating the roll out of the LWP including establishing systems of monitoring the quality of HIV services to MARPs in USG focus states. The LWP is an outreach strategy in the NACP-III aimed at generating a cadre of trained local personnel to work with MARPs, in the rural areas. India is not supporting a national CT event as it may not be appropriate for a concentrated epidemic. The estimated burden of HIV/TB co-infection is 900,000 million cases and between 1-13% of TB patients are co-infected with HIV depending on the setting. As part of the NACP III, NACO plans to diagnose and treat 85% of the people co-infected with HIV/TB in India through provider initiated counseling and testing (PICT) for TB clients. This will require training lab and nursing staff at 12,500 designated TB microscopic centers on HIV CT. This expansion should increase the number of TB patients tested from 490,000 in 2008 to over 1.2 million by 2015. Technical support to NACO and the National TB Control Program for planning and implementation is being provided through a USG-supported WHO consultant. NACO is investing intense resources in strengthening the capacity of institutions and individuals to improve the quality of CT programs. Training institutions will provide intensive training and onsite mentoring of all CT staff. GFATM Round 7 funding will be used to develop the training capacity at 40 nursing colleges and 40 national counseling training institutions to train nursing and counselor staff at ICTC. NACO recommends rapid HIV tests which provide results to the client in 30 minutes. The rapid scale-up and integration of CT services necessitates the need for a robust quality assurance process. The quality of counseling services will be assessed through an annual mystery client study. The quality of HIV testing will be maintained through an External

Quality Assessment Scheme (EQAS) implemented in all states. NACO also plans to conduct operation research (OR) studies to address bottlenecks in scaling-up and improving the quality of CT services. Examples of OR studies include identifying access points for testing MARPs and confidentiality issues in community and home based testing. The USG will use its in-house research expertise to guide NACO in conducting OR studies. According to available reports, 40% of those tested positive at ICTC do not reach ART Centers. NACO is addressing this issue by strengthening the referral linkages between ICTC and care and treatment services at the district level by establishing a coordination mechanism among the various service providers. The entire national CT program is funded through GFATM. Other donors do not provide significant funding at the national level although some organizations, such as the Population Foundation of India, provide care and support under the GFATM and have close links with local CT services. The USG focuses on providing technical support to the State AIDS Control Societies (SACS) for scaling up CT services and developing model approaches for CT and demand generation targeted at MARPs. Accomplishments since last COP The USG_s major contribution to the national programs was to demonstrate the value of community-based and private sector approaches in focus states to improve access of CT services to MARPs. In Karnataka (KN), the USG pioneered the Link Worker Program concept to mobilize rural MARPs to utilize CT services, a model now recognized by NACO and scaled up nationally through the support of the GFATM. The KN program was developed as a link worker learning site for sharing best practices with other states. In Tamil Nadu (TN) and Maharashtra (MH), NACO co ntracted USG partners to implement the link worker program in all high-prevalence districts and these will serve as demonstration programs for the national LWP. Similarly, the USG program successfully demonstrated the expansion of CT services through partnership with the PHC program in high prevalence districts of Andhra Pradesh (AP). The program strategy included placement of a nurse and capacity building of the PHC team in providing user friendly CT services to high-risk individuals. Ongoing supervision was an important component of the model. NACO has adopted this model in scaling-up CT services through integration with the NRHM program in the 24-hour PHCs. The USG is playing a lead role in the country demonstrating private sector models for quality CT. The USG has collaborated with 19 private medical hospitals in TN and a consortium of 18 private medical colleges in AP to provide quality testing, care and treatment services to vulnerable populations. In addition, USG-funded technical support units which provide technical assistance (TA) to SACS have expanded CT services through public-private-partnership programs. For example, in MH and TN, the TSUs have assisted the SACS in setting up over 125 private sector CT sites. USG FY10 and FY11 Support In FY10, the USG will support NACO_s expanded CT plan (2010-2015) to consolidate and strengthen the CT program and expand CT service coverage through a variety of approaches to achieve the national targets. 1. An overarching NACO strategy is to increase the uptake of CT services by adopting various approaches to improve access. The USG will support the NACO objectives of increasing CT services among MARPs (10% to 90%) and bridge populations (10% to 50%) through community-based CT approaches including support for demonstration projects. The projects will include mobile CT services and identification of best practices to address MARP stigma and discrimination issues. (a) In TN, MH and KN, the USG will support demonstration programs of the peer led community mobilization approach to increase the uptake of HIV testing among MARPs. Referral mechanisms will be established between the peer educators in MARP interventions and the CT teams and the coverage of HIV testing will be monitored regularly. Innovative strategies will be adopted to reach new sex workers who are at increased risk of acquiring HIV. Repeat testing and follow-up counseling will be promoted. The project will be evaluated and the findings will be disseminated to NACO. The USG will develop guidelines based on the lessons learned and will advocate with NACO to replicate the program nationally. (b) The USG will continue to support the link workers program in TN, MH and KN to use the sites for training and demonstration projects. GFATM will support the CT services. Similarly, in MH, the USG will support the mobile CT programs serving the high-risk migrant populations. Both these models will be evaluated and the findings will be disseminated to NACO, and the lessons learned from these models will strengthen the national link workers program including guiding policies on scale-up and quality. (c) NACO has identified the need for developing models for demand generation campaigns to increase uptake of CT services targeted for MARPs. The USG will support TA for the development of these campaigns and for replication of campaigns nationally.

For example, a community-based media campaign which includes street plays, puppet shows and local folk media tailored to the sub-cultures and community structures of FSW, MSM and migrant populations will be developed. 2. NACO has given a high priority to expanding CT services in the private sector. In FY10, the USG will evaluate the effectiveness of the various private sector CT models and will report the findings to NACO. The USG will also advocate with NACO to form a Technical Resource Group (TRG) on private sector HIV services. The TRG will be a forum to guide national policies on private s ector HIV/AIDS initiatives. The USG will provide TA to SACS through the technical support units in six states to expand the private sector CT services. 3. NACO is expanding CT services through integration with the NRHM. In FY10, the USG will build the capacity of SACS in the USG states to carry out integration of HIV services into the NRHM. While at the same time, efforts will be put to strengthen the community-based CT services targeted at MARPs including establishing linkages with the government CT services. USG PEPFAR will leverage TA from the Reproductive Health Division of USAID to integrate HIV activities into Maternal Child Health in India. At the national level, the USG will assist NACO in developing guidelines to replicate the integration of HIV services in other states across India. 4. The USG will support NACO_s efforts in developing models of linkages between CT and care and treatment services. For example, the District AIDS Prevention Control Unit (DAPCU) will set-up referral systems between the CT and care and support centers, hold joint meetings and monitor the efficiency of referral linkages. The USG will provide TA to SACS to implement the prevention to care continuum in the USG focus states. 5. The USG will also provide TA in developing guidelines on quality counseling including risk-reduction counseling for both people tested positive and negative; and in USG states, TA will be provided to conduct training of counselors, and provide monitoring support to ensuring provision of high quality counseling services. In FY09, the USG assisted Johns Hopkins University in developing an interactive training toolkit with a video accompanied by a facilitator_s guide for training of trainers (TOT) who will conduct training for counselors at ICTCs. This interactive training toolkit, with a stop and start video component demonstrating ideal counseling sessions, was developed per NACO_s request and used during the ICTC counselors_ trainings in the country. In FY10, JHU CCP will provide TA to NACO in replicating the training toolkit in other languages. 6. The USG will also provide TA to NACO to develop programmatic studies on community led CT approaches. Specifically, TA will be provided in designing these studies on: a) Structural, social and economic barriers to access CT services and b) Identifying CT access points for MARPs. 7. The USG will assist NACO in developing strategies to mitigate gender concerns in HIV/AIDS programs. NACO prioritized addressing the double stigma and discrimination MARPs face in community and health care settings. NACO will train CT teams to be sensitive to the needs of MARPs and provide user friendly services. USG will assist NACO in developing strategies to mitigate gender concerns among MARPs and vulnerable populations nationally.

Technical Area: Health Systems Strengthening

Budget Code	Budget Code Planned Amount	On Hold Amount
OHSS	10,697,785	
Total Technical Area Planned Funding:	**10,697,785**	**0**

Summary:

Context and Background The first five years of PEPFAR coincided with the strategic planning and development of the third phase of India_s $2.5 billion National AIDS Control Plan-III (NACP-III), implemented by the National AIDS Control Organization (NACO). NACP III outlines an ambitious time-line to deliver large-scale outcomes, e.g., targeted prevention interventions at over 2000 sites for most-at-risk populations (MARPs) across 31 states; antiretroviral therapy (ART) in more than 200 centers; and provision of counseling and testing (CT) services in nearly 5000 centers. During the development of NACP-III, the USG participated in a number of Technical Working Groups (TWG) and assessments to

identify operational and HSS requirements to rapidly scale up the national program. Consequently, NACO added two key positions to strengthen NACP III: a full time finance director to improve administrative and fiduciary management and a Joint Secretary with previous maternal and child health experience to facilitate integration of spillover activities. The newly established District AIDS Prevention Control Units (DAPCUs) will help facilitate decentralized HIV/AIDS program management to the district level. By 2012, DAPCUs will be absorbed into decentralized autonomous bodies called District Health Societies and tasked to integrate all health programs at the district under the larger $10 billion National Rural Health Mission (NRHM) program. The USG team makes important contributions to HSS in India through a spectrum of activities that intersect virtually all technical areas. Those being accomplished through support to the Technical Support Units (TSU) tasked to build the capacity of the state level AIDS service delivery in prevention and care and treatment programs including laboratory strengthening. Other contributions include working with State AIDS Control Societies (SACS), utilizing human resources by placing advisors and consultants at the national and state level in key technical areas, investments in health financing in exploring innovative models of private health insurance for people living with HIV/AIDS (PLHIV) and information systems for building national/state Strategic Information systems. Coordination and other Players Other donors that contribute significantly are the Bill and Melinda Gates Foundation (BMGF) in implementation of prevention programs for MARPs. The Clinton Foundation focuses on building the capacity of health care providers in pediatric ART. The USG engages closely with various Ministries such as Ministry of Women and Child Welfare (MWCD), Ministry of Labor and Employment (MOLE), Ministry of Rural Development (MRD) and the Ministry of Human Resource Development (MHRD) to build their capacity in HIV/AIDS programming. NACO has nominated the USG as the lead for NACO_s own public-private partnership (PPP) programs in HIV/AIDS prevention, care and treatment. USG support in building the capacity of the networks of PLHIV in India has contributed to the emergence of a strong network of local and regional chapters of the Indian Network of Positive People (INP+). A USG-supported institutional HSS review of INP+ highlighted the positive impact of USG support to INP+, including expansion of positive prevention. Key HSS committee memberships that the USG currently holds include: 1. NACO-led steering committee of donor partners, a forum for multilateral and bilateral partners; 2. State project steering committees in the priority USG high prevalence states; 3. National TWGs in Laboratory Strengthening, Behavior Change Communication (BCC), OVC, Prevention, and Care and Treatment; and the 4. Technical Panel for BMGF. The USG is a member of the India Country Coordinating Mechanism (CCM) of the Global Fund for AIDS, TB and Malaria (GFATM). The USG supported the Country Coordinator position till March 2009 when the position was transitioned to GFATM. The USG represents the bilateral donors on the CCM along w ith DFID and the French Mission and supports CCM Secretariat capacity building. Challenges include the frequent changes in leadership of SACS project directors and quality of health care providers in service delivery. Attraction and retention of qualified staff with managerial and technical skills at NACO and SACS is a concern. In addition to ad hoc requests from NACO, capacity development processes and evidence-based programming are also systemic challenges. Emerging issues include points of duplication between the functions and functionaries of the streams of the National Reproductive Health Mission (NRHM) and NACP, such as multiple trainings and multiple lab technicians in a single facility. Additionally, cross-cutting issues (such as BCC, counseling and cross referrals) are not synergized to enhance effectiveness of service delivery. Accomplishments since last COP The USG continues to play an active role in the NACP-III roll out. USG-supported programs in the high prevalence priority states complement and leverage the $400 million GFATM program in India, to provide community-based demand generation activities, capacity building of health care providers and state-of-the-art strategic information systems. The USG will participate in the mid-term review (MTR) of the NACP to be conducted later this year. Over 13 assessments in a number of thematic areas are planned as part of the MTR, including the USG supported nationwide behavioral sentinel surveillance (BSS), triangulation exercises with key data sets and the evaluation of targeted interventions for MARPs and STI prevention programs. 1. Institutional capacity building: The USG supports key technical specialists at NACO and SACS levels in the following areas: CT, PMTCT, ART, surveillance, epidemiology and monitoring and evaluation (M&E). NACO_s annual evaluation of Technical Support Units (TSU) demonstrated that the seven USG-supported TSUs were among the

better-performing TSUs in terms of scaling up of activities and monitoring. USG support at the DAPCU level for developing district action plans in high prevalence USG priority states and the northeast region have identified synergies at the service provider and service delivery levels to optimize convergence across various health systems. The USG-supported state-of-the-art laboratory at the Government Hospital for Thoracic Medicine at Tambaram (GHTM), Chennai is recognized as one of the centers of excellence (COE) by NACO. The USG lead the national efforts to strengthen the 13 National and 120 State Reference Laboratories to improve quality of diagnostics and testing. USG support contributed to strengthening of the laboratories of the Indian Armed Forces Medical Services (AFMS). The USG established the HIV/AIDS unit to integrate HIV/AIDS activities into schemes of the MWCD. 2. Technical support and advocacy: The USG supported an HSS assessment of various technical positions at NACO which revealed a significant number of vacancies and duplication of federal-state human resources. Consequently, the USG led a consortium of donor partners to develop a common human capacity development plan that will leverage resources for optimal human resource utilization. USG-supported policy and advocacy activities include the development of a national policy guiding the role of the private sector in HIV/AIDS services under NACP-III, which is expected to be released as soon as the economy improves. The USG was also responsible for the country_s first group health insurance from the private sector for PLHIV, which was launched by the Director-General of NACO. USG support facilitated the development of a number of guidelines such as accreditation of laboratories in the private/NGO sector. USG advocacy efforts for a stronger focus on OVC resulted in the approval of a national pilot to field-test the operational guidelines developed by the USG. The USG_s model program piloting task-shifting through the nurse-practitioner (NP) expanded to 266 facilities as part of long-te rm transition plan to the NRHM by end of 2010. USG TA for communication at NACO and SACS built strategic health communication leadership and facilitated the development of thematic communication strategies for specific populations. The USG_s FY10 HSS strategy will focus primarily on the provision of TA in two areas: of leadership and governance and service delivery. This includes institutional strengthening at national, state and district levels as the USG transitions from direct support for field-level implementation towards a strategic TA role to NACO and the SACS. The USG focus in FY10 on health financing and information systems will be modest; while investments in human resources through the provision of TA will incorporate an exit strategy plan with milestones. The USG_s comparative advantage in TA for leadership and governance will focus on the following four components: 1. Institution capacity building: USG support to TSUs will be restructured to focus on planning and management of prevention intervention programs including grants management and capacity building of training institutions. The USG will support the development of evidence-based state and district annual action plans in USG high prevalence priority states. The restructuring will encompass field-based technical positions that improve on-site TA, field-level M&E and capacity building of the DAPCUs. At NACO_s request, the USG will support the national TSU. The USG will support the key technical positions of team leader, epidemiologist, information technology specialist and M&E specialist. At the state level, USG support will provide TA in areas of M&E, clinical mentoring and in-service training of health care specialists including nurses and counselors. At district level, the USG will support DAPCUs in development of district action plans. The USG will coordinate with INP+ and its district level networks (DLN) for the development of an integrated capacity building plan to pilot the Greater Involvement of People living with HIV/AIDS (GIPA) strategy. 2. Laboratory strengthening: The USG will continue to provide TA to NACO in laboratory system strengthening and build institutional capacity of the National AIDS Research Institute (NARI) and the National Institute of Biology in New Delhi. The USG will develop a capacity building plan for the accreditation of national and state reference laboratories including training in quality assurance systems. USG support will facilitate GHTM to serve as a learning site for clinical mentorship and quality of services for the remaining 13 COE by NACO. 3. Leveraging Global Fund: The USG will work in close collaboration with the India GFATM CCM Secretariat to provide TA to develop the national strategy application and support regional and national consultations to improve civil society and private sector engagement. The USG will facilitate the consolidation of the M&E framework for all GFATM Rounds. 4. Improved private sector engagement: The USG will facilitate TA for improved engagement in implementing HIV/AIDS prevention, care and treatment programs such as scale up of PMTCT and

advocacy for policies on scaling up HIV/AIDS interventions with the informal sector. The USG-supported innovative healthcare financing initiative which led to the first private sector insurance for PLHIV will be scaled up to other USG high prevalence priority states and expanded to the public insurance sector. A strategic partnership with the Insurance Regulatory Development Authority (IRDA) in collaboration with NACO and HIV positive networks will be developed to advocate for HIV inclusion in general health insurance schemes. The USG will expand its innovative models of service delivery through augmentation of the HIV diagnosis, care and treatment services in the private sector and collaboration with consortium of private medical colleges.

Technical Area: Laboratory Infrastructure

Budget Code	Budget Code Planned Amount	On Hold Amount
HLAB	460,000	
Total Technical Area Planned Funding:	**460,000**	**0**

Summary:
Context and Background Laboratory systems in India have improved in recent years. However, uneven service quality and inequities in access to services remain a challenge. India has an abundance of clinical laboratories with uneven distribution, quality and systems linkages, and no single government authority responsible for regulating laboratories. There are some high-performing laboratories, the majority in the private (for profit) sector, some in government research institutions, and a few in premier medical colleges. Unfortunately, most individuals requiring HIV-related laboratory services, including People Living with HIV/AIDS (PLHIV), do not have access to these high-quality laboratory services due to geographic and cost constraints. The total volume of HIV-related tests that can be performed by existing laboratories is also significantly less than the national need. The Government of India (GOI) is just beginning to recognize the need for regulatory mechanisms and accreditation mechanisms to ensure the quality of laboratory services. Laboratory services are an integral part of the national HIV testing, care and treatment program proposed by the third phase of the National AIDS Control Program (NACP III). The scope of NACP III is limited to control of the HIV epidemic, but improvements in the HIV sector should also improve the existing tiered national system of laboratory services. NACP III also addresses human resource development by training additional staff and task shifting, e.g., training paramedical staff to handle HIV testing to increase the number of personnel qualified to test for HIV. The National AIDS Control Organization (NACO) recognizes that the lack of an institutionalized approach to quality assurance is a weak aspect of India_s health system. It is addressing this issue in the context of laboratory support for HIV services. NACO has instituted significant national policy changes related to CD4 testing, such as encouraging baseline CD4 testing of all identified PLHIV cost-free at NACO-funded antiretroviral therapy (ART) centers. With support from the Clinton Foundation, NACO has purchased 155 FACS Caliber and FACS Count CD4 machines and placed them in government institutions. In 2008, NACO initiated an independent assessment of the 13 National Reference Laboratories (NRLs) across India. The assessment, led by the USG in collaboration with the World Health Organization (WHO), provided an objective report of the quality of HIV testing and provided recommendations for further strengthening of these laboratories. Issues identified in the assessment are being addressed. It is anticipated that the NRLs will be accredited by the National Accreditation Board for Laboratories, with the expectation of better support for the national External Quality Assurance System (EQAS) for HIV testing. In August 2009, NACO laboratory services started infant DNA Polymerase Chain Reaction testing in 7 centers. HIV resistance testing is being carried out in a reference laboratory as a pilot project. Viral load testing is being piloted in 10 laboratories including some national reference laboratories. Despite these steps and a growing recognition of the importance of a strong laboratory system within a comprehensive plan for HIV services, many challenges remain. Training modules and guidelines for various HIV

laboratory tests are not followed by many training centers. Standard operating procedures are not found in most of the national and state reference laboratories and 4,900 Integrated Counseling and Testing Centers (ICTCs). Even with additional FACS Caliber and FACS Count CD4 machines in place, laboratory capacity for CD4 tests is insufficient to meet current demands, leading to heavy workloads for existing CD4 testing laboratories. This systems issue is related to government restrictions on operating hours, lack of workforce productivity incentives, and administrative/logistical issues (i.e. supply chain management, sta ffing/human resources, equipment maintenance). The GOI_s reluctance to outsource CD4 testing to high-quality corporate or university laboratories is another constraint. Diagnosis and treatment for opportunistic infection (OI) represents an additional challenge. There are no immediate plans to upgrade tuberculosis/bacterial culture systems, latex antigen testing, or fungal cultures for Cryptococcus in labs linked to ART centers. Laboratory capacity for testing for common sexually-transmitted infections (STIs) and Hepatitis B and C is uneven. The USG is the major donor providing ongoing technical assistance (TA) in laboratory systems strengthening. TA is coordinated with the Laboratory Services Division at NACO. The USG assists in leveraging funding and other opportunities with other partners in the Ministry of Health and Family Welfare (MOHFW) and the private sector to further NACO goals and objectives. India has considerable, but fragmented, microbiological and general laboratory expertise. A framework for a tiered laboratory system exists but needs to be made fully functional and actualized. Accreditation, viable scopes of work and useful information management systems need to be integrated into a holistic, quality laboratory system. While supporting this system is beyond the scope of NACO and NACP-III alone, NACO recognizes the need to improve laboratory services and address quality, and has initiated steps to assess, strengthen and accredit public sector laboratories with USG assistance. Beyond HIV, there is a need for other MOHFW programs and external partners to work with NACO to build broader laboratory capacity and quality systems in a sustainable way. Accomplishments since last COP The NACO initiated, CDC/WHO-led, independent NRL assessment report was completed and shared with the GOI. Based on the recommendations that arose from the assessment, the GOI has laid down a road map for strengthening NRLs, including applying for accreditation for NRLs. NACO requested the USG to conduct a similar exercise covering the 117 State Reference Laboratories (SRL). This started in August 2009 and will be an important step towards strengthening HIV testing through all ICTCs, and will extend external quality improvement and accreditation to the next tier of the national laboratory system. The CDC Team was also expanded in 2008 to include a senior laboratory expert to guide and support this NACO initiative. The report from the assessment of 117 State Reference Laboratories is expected to be submitted to NACO by mid-October. This report will help NACO identify the needs and gaps existing within SRLs and take corrective action. The USG, in active collaboration with the Clinton Foundation and UNICEF, provided support to NACO to begin to roll out early HIV diagnosis in infants. The current testing methodologies allow testing for HIV antibodies after the child is 18 months old. The proposed plan for early infant diagnosis (EID) will use a DNA PCR testing algorithm developed with USG support to test infants from six weeks to six months of age. USG has continued to provide significant TA and guidance on CD4 testing scale-up and quality assurance systems to NACO and the Clinton Foundation. Support is also continuing for a CDC/WHO-developed HIV Rapid Test Toolkit that is being incorporated into various in-country training programs and curricula for laboratory technicians. USG TA and support for the state-of-the-art laboratory at the Government Hospital for Thoracic Medicine (GHTM) at Tambaram are also continuing. GHTM has been recognized as one of the leading laboratories in India providing HIV services. In the period 2008-09, the GHTM laboratory performed approximately 1,193,841 tests, including 26,632 CD4 tests and 139,028 Acid Fast Bacilli (AFB) smears. Bacterial and fungal cultures and basic chemistry and hematology tests were routinely performed for the approximately 35,700 PLHIVs that were cared for in 2008-2009 at GHTM. Concrete evidence of the GOI_s veritab le commitment is evident by the decreased USG funding commitments as the Tamil Nadu state budget is absorbing a substantial portion of recurring costs, increasing potential for sustainability of the project. The USG continues to support collaboration with the private laboratory sector in Andhra Pradesh (AP) and Tamil Nadu (TN) to expand access to HIV-related tests. The AP model includes a network of 15 private medical colleges and 45 private sector ICTCs, which provide quality assurance for HIV testing, cascade training, monitoring and regular supervision. An

important aspect of this intervention is USG support to the network for centralized CD4 testing and transportation, an innovative mechanism to ensure that all 15 colleges have access to HIV-related laboratory tests at a reasonable price. The TN pilot project provided training in proper testing, counseling and quality control techniques to local for-profit labs performing high volume HIV testing, with subsequent bi-annual inspections and reviews. In return, laboratories were certified by Tamil Nadu State AIDS Control Society (TNSACS) and were eligible to receive free HIV test kits if they agreed to perform HIV testing for $1.25, approximately 50-70% less than most private laboratories currently charge. The USG continued to support the laboratory capacity of the Armed Forces Medical Services (AFMS). Provision of CD4 equipment, laboratory reagents and HIV test kits by USG to the AFMS strengthened their HIV services, including the services of five newly-established _immunodeficiency centers_ for Indian military personnel and their families. As part of the transitioning and sustainability process, the USG provides TA to facilitate AFMS_ procurement of laboratory equipment through other sources. This activity has evolved and matured to the point where new activity is no longer a priority. Also, the long term effort is to transfer the titles of all equipments to AFMS. Until that time it is crucial that the equipment is maintained and serviced allowing laboratories to remain fully operational. USG FY10 and FY11 Support HIV-related laboratory needs in India are great, but gains made in the HIV laboratory sector will affect the depth and breadth of the entire tiered public laboratory system in India. The USG will continue to provide significant leadership in the area of laboratory sciences and policy development, while limiting support primarily to technical assistance and training owing to current budgetary constraints. In FY10, at the national level, USG will continue to provide targeted laboratory TA to NACO, coordinated by the USG senior laboratory expert with support from USG care and treatment experts. The USG will continue to collaborate with, and leverage, other laboratory partners_ resources to support critical areas under NACP-III. Key areas of focus will include: continued support for full NRL accreditation; completing the SRL assessment and assisting NACO in implementation of the recommendations; and implementing quality assurance programs and supporting the scale up of quality, essential HIV tests through the public, private and military sectors. As part of a broad USG initiative to support India_s ART roll-out, USG will provide intensive technical assistance to expand CD4 testing capacity nationally and pilot strategies to increase CD4 testing efficiencies, including outsourcing of some testing to reputable private laboratories. The USG will continue to develop strategies and materials to support quality assurance systems in the national, tiered laboratory system. This started with the NRL and SRL assessments, and continues with laboratory accreditation. The assessments_ recommendations will be vital to develop the accreditation strategies, to identify training needs to fill identified gaps, and to define and develop a LMIS proposal. The next step will be to implement laboratory management information systems (LMIS). The magnitude and variety of data that is generated from testing laboratorie s can be disseminated to clinicians for better patient care and management. It would also facilitate analysis of data both at the State and National level. The USG will also work with NACO to refine the National Laboratory Guidelines. The USG will expand access to quality, essential HIV-related laboratory tests. The USG will support implementation of state-of-the-art molecular diagnostics in HIV testing, care and support, to expand the NACP III vision of laboratory support for evidence-based testing and treatment. This will include TA support to laboratories conducting viral load testing, implementing rapid methods for diagnosis of OIs, and supporting HIV care and treatment. Also, the USG plans to leverage its international technical experience to provide laboratory management training to senior level laboratory personnel of NRL and SRL systems and training on innovative techniques and useful cost effective methods like dry blood and dry tube specimen. The USG will support the activity of early infant diagnosis by providing TA. Training manuals and testing algorithm developed by CDC will be used for this program. The USG will continue to provide technical support to states focused on quality assurance systems, scale-up of CD4 testing, and collaboration with private sector laboratories. In AP, the USG will continue to work with APSACS on strengthening quality assurance systems in the over 700 government HIV testing centers, and on laboratory training to build capacity to diagnose commonly occurring OIs. Similar laboratory support will be provided in TN and Maharashtra states through USG-supported Technical Support Units.

Technical Area: Management and Operations

Budget Code	Budget Code Planned Amount	On Hold Amount
HVMS	4,205,685	
Total Technical Area Planned Funding:	**4,205,685**	**0**

Summary:
(No data provided.)

Technical Area: OVC

Budget Code	Budget Code Planned Amount	On Hold Amount
HKID	1,168,116	
Total Technical Area Planned Funding:	**1,168,116**	**0**

Summary:
Context and Background India is the second most populous country in the world and has 2.31 million people living with HIV/AIDS (PLHIV). Of this total, 39% are women and 3.5% are children. With a national HIV prevalence of 0.34%, India continues to have a concentrated epidemic. The national prevalence of HIV among pregnant women attending antenatal clinic (ANC) is 0.48%. However 200 districts have been identified as HIV high burden districts, with HIV prevalence in ANC attendees of more than 1%. It is estimated that India has 3-4 million children who are affected by HIV/AIDS, of which 95,000 are living with HIV. Mother to child transmission is the most significant route of HIV transmission in children below 15 years of age in India and accounts for 4.3% of HIV transmission. Accurate, timely and valid data on orphans is not available in India. In 2003, an estimated 35 million children in India under the age of 18 had lost one or both parents due to all causes, approximately 9% of all children. Major causes of orphanhood include emergency situations such as natural disastes, terrorist activities, and illness, including HIV/AIDS. The impact of AIDS is most apparent in the high burden districts. Under the leadership of the National AIDS Control Organisation (NACO), the third phase of the National AIDS Control Plan (NACP-III, 2007-2012) aims to halt and reverse the epidemic in India over the next five years. In addition to a focused prevention program, provision of care, support and treatment to a large number of PLHIV, including children infected and affected by HIV/AIDS, is well articulated in the plan. In the long term, NACOs goal is to achieve the highest quality of life for HIV-infected and affected children and their families through delivery of a comprehensive package of services. The three nodal ministries; Women and Child Development (MWCD), Social Justice and Empowerment (MSJE) and Human Resource Development (MHRD) are envisaged as active collaborating partners to support outreach to children affected by HIV/AIDS. Although the onus for HIV programming lies with NACO, the success in ensuring access to services for these children can only be achieved with collaboration and coordination with ministries like MWCD, MSJE and MHRD. MWCD launched the _Integrated Child Protection Scheme (ICPS)_in 2009 that aims at setting up Child Protection Societies at state and district level. The ICPS will provide care and protection services to all children including children affected by HIV/AIDS. MWCD has an ongoing Integrated Child Development Scheme (ICDS) that caters to all children less than six years of age for supplementary nutrition services and early childhood development. The National Plan of Action (NPA) for Children 2005 (Section 16) emphasized issues of children infected by HIV and affected by AIDS. The NPA goal has been to stop the spread of HIV by 2010 and to reduce the proportion of children infected with HIV by 20% by 2007 and by 50 % by 2010. To date, progress toward targets has not been

seen. However, the main challenge in India is that OVC programs are a low priority area for NACO. As a key member of the National Task Force Committee on Children Affected by HIV/AIDS, the USG advocates for policy and guidelines for OVC. Collaboration with UNICEF has successfully resulted in the launch of a National Policy framework for children and AIDS, followed by USG-supported development of national guidelines. The national guidelines for implementing OVC programs outline steps for ensuring access to care, support, treatment, and protection services for children affected by HIV/AIDS and define the minimum package of services for such children. These are: health/medical care, psychosocial support, nutrition support, education support, and special services such as social protection, economic strengthening, legal support and shelter/alternative care. Accomplishments since last COP The USG has been supporting the OVC pol icy and advocacy efforts at the national level in collaboration with UNICEF, NACO, Family Health International (FHI), International HIV/AIDS Alliance, Clinton Foundation and Francois Xavier Bagnoud (FXB). The National Task Force team has developed the state and district level operational guidelines for children affected by HIV/AIDS. The USG along with UNICEF have supported NACO in developing the national scheme for children affected by HIV/AIDS. This scheme is awaiting approval and final launch by NACO. The purpose of this National Scheme is to ensure access to all the essential services by children affected by HIV/AIDS through coordination and the establishment of linkages with various existing service providers at all levels. This scheme will be rolled out in 135 high burden districts. In 2009 GOI approved the joint proposal by UNICEF, United Nations Development Fund for Women (UNIFEM), the USG, and FHI to establish the HIV/AIDS Unit in the MWCD. The HIV/AIDS unit will facilitate the mainstreaming of interventions for HIV care among women, girls and children and establish strong coordination among the departments concerned in MWCD and NACO. This team will also facilitate the implementation of the OVC guidelines and integration of HIV training in the curriculum of the MWCD outreach workers. This includes action planning (for national, state, district and block level operations), provision of technical inputs on capacity building of the existing systems and mechanisms, and initiating additional services required to address the needs of these children, especially in high burden districts and states. The USG provided technical assistance to NACO in estimating the number of OVC in 10 pilot districts. The district level estimate of OVC in the 10 HIV high burden districts were calculated from the existing data of district population, sex ratio, estimated number of MARP, HIV prevalence in MARP, Antenatal care data, HIV prevalence in ANC clinic attendees and HIV prevalence at the sub-district level. This methodology is being peer reviewed for replication and applicability across all the HIV high burden districts. USG partners in the state of Tamil Nadu have successfully mobilized financial resources from the State Government of Tamil Nadu for addressing the needs of OVC. The State AIDS Control Society has registered a trust named Trust for Children Affected with AIDS (TNTCAA) to meet the needs of children. This initiative is the first of its kind in India. TNTCAA will support education, nutrition and medical needs of more than 1,500 OVC in its first year of operation. The USG supports the OVC consultant position at the state level in the Tamil Nadu State AIDS Society. The USG Samarth project developed a life skills toolkit in collaboration with NACO and MWCD to respond to the needs of USG supported NGOs who are working with children who are infected and affected by HIV/AIDS. Samarth project developed a child counseling protocol on HIV testing, disclosure and support; detoxification and rehabilitation protocol for substance using children and adolescents; and child-friendly communication materials for HIV prevention and awareness. The USG supported OVC care programs have made significant progress in the past year, including providing essential services to over 6,000 OVC in focus states. This was done through USG partners AIDS Prevention and Control Project (APAC), the Avert Society Project, Samarth and Samastha projects. In Karnataka and five coastal districts of AP, USG funded Samastha project worked with PLHIV networks to link OVC specific interventions with prevention of mother to child transmission of HIV (PMTCT), antiretroviral therapy (ART) and care and support services. Priorities include providing essential services for children of most-at-risk populations (MARP) and HIV-infected single mothers. Programs for single mothers include linking women to self-help groups, legal assistance for widows_ and children_s rights, and facilitating birth regist rations. USG FY10 and FY11 Support The USG will continue working at the national level to ensure effective implementation of the Policy Framework for Children Affected by AIDS and the national scheme for children affected by AIDS. The priority areas for the USG_s technical assistance (TA) to NACO include

evidence-based strategic planning, improving quality of OVC programming and ensuring coordination of care at all levels. 1. Provide timely and sustained TA to NACO for the adoption of the family centered approach in OVC care and support projects across all high prevalence states in India. The USG will support program staff at NACO to ensure linkages between PMTCT and OVC programs by supporting policy development and implementation across all projects. 2. Provide ongoing TA to MWCD to support the HIV/AIDS unit_s core functions and mainstream HIV prevention interventions for women, girls and children into routine schemes, ensuring the provision of nutrition support and social protection for vulnerable children and children affected by HIV/AIDS. The USG will provide TA in developing operational guidelines for Community Care Centers and charitable homes and other facilities managed by State AIDS Control Societies (SACS) and the Departments of Women and Child Development and Social Welfare supporting children infected with and vulnerable to HIV/AIDS. 3. Provide TA to the national scheme for children affected by AIDS through the development and implementation of internal and external quality assurance methods to ensure provision of the basic services of health care, nutrition and food security, shelter and care, protection, psychosocial support, education and economic strengthening. This will include development of service quality indicators. Quality improvement information will be shared with staff, volunteers, community leaders and other stakeholders, as well as children and their families to continuously improve programs_ response to the need for wide-scale, long-term efforts that address direct and indirect impacts of AIDS on children, families and communities. 4. Strengthen the SACS and District AIDS Prevention and Control Unit_s (DAPCU) capacity to implement OVC programs. There is limited understanding of the guiding principles for OVC programs and of the elements that comprise a complete package of services for an affected child. Following the 2007 release of the National Policy on Children and AIDS, the national operational guidelines are being strengthened to include case studies and best practices. The focus of USG activities in USG priority states will be on capacity building for operationalization of the OVC guidelines, specifically building the capacity of the SACS and the new DAPCUs to plan, manage and monitor OVC programs. Training will also be carried out for SACS-supported local organizations to strengthen the depth and quality of OVC programs. 5. At the district level USG partners will continue to support DAPCU in the USG priority states to fully integrate OVC specific interventions with the PMTCT, HIV care and treatment services and child health programs. The DAPCU will play supportive role to facilitate effective coordination at the district level between various departments (Social welfare, Women and Child Development, Education) and the District Administration to ensure that all identified children affected by HIV/AIDS under the scheme are able to avail these services. 6. The USG, through partners working at the community level, will use social mobilization to strengthen the capacity of family members to overcome stigma and ensure access to services for all affected children and family members. The USG partners will work to develop and pilot community initiatives that provide families with access to comprehensive HIV prevention, care and support services including life skills education, non-institutional care, psychosocial support, medical care, referral and linkages to VCT and ART centers, linkages to education su pport, vocational training, legal and economic support.

Technical Area: Pediatric Care and Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
PDCS	190,017	
PDTX	22,000	
Total Technical Area Planned Funding:	**212,017**	**0**

Summary:
Context and Background There are an estimated 95,000 children living with HIV in India. National

Sentinel Surveillance (NSS) does not directly track HIV prevalence among children. As a result only estimates of infected children are available. Mother to Child Transmission (MTCT) is by far the most significant route of HIV transmission infection to children below the age of 15 years. Given that there are an estimated 27 million deliveries annually in India, an estimated 85,000 infected women become pregnant and give birth to 25,000 infected babies each year. In 2008, 4.15 million pregnant women (15.3% of all pregnancies) received prevention of mother to child transmission (PMTCT) of HIV services, of which 19,986 tested positive. Only 51% of the mother-baby pairs received Single Dose Nevirapine (SD NVP). Approximately 53,000 children living with HIV are registered for care at 217 ART centers and currently 14,474 children are receiving antiretroviral therapy (ART) with 39% being girls. Based on the eligibility criteria, 27.3% of HIV infected children have been started on treatment. However a significant number of children are yet to be identified who may be eligible for HIV-related services, care and treatment. At present DNA polymerase chain reaction (PCR) diagnosis is not readily available in India, restricting diagnosis to children over 18 months of age. NACO is planning to introduce Early Infant Diagnosis (EID) by DNA PCR and make it routinely available at the government Integrated and Counseling and Testing Centers (ICTC) and ART centers. The majority of these centers are in the HIV high burden districts. Additional barriers to universal pediatric HIV care and treatment are: poor pediatric HIV service provider clinical knowledge and skills; lack of accurate surveillance and program planning data for children less than 15 years of age; pervasive stigma and discrimination which can interfere with diagnosis and disclosure of HIV positive status and access to treatment; inadequate follow up of infants born to infected mothers identified by the PMTCT program; imperfect convergence between HIV and maternal child health (MCH) services; and absence of a standard package for care and support of children affected and infected with HIV in many states. The percentage of HIV exposed infants provided with cotrimoxazole (CTX) is negligible in India because of the poor PMTCT coverage and high loss to follow-up of HIV positive pregnant women. The National AIDS Control Organization (NACO) spearheads the Government of India (GOI) response to the HIV epidemic. The guiding map is the third phase of the National AIDS Control Program (NACP III), linking pediatric HIV services with other GOI departments and nongovernmental organizations (NGOs), including the Ministry of Health and Family Welfare_s (MOHFW) Reproductive and Child Health (RCH) Program, the Ministry of Women and Child Development, the Indian Council of Medical Research, Federation of Obstetricians and Gynecologists of India (FOGSI) and the Indian Academy of Pediatrics. The National Pediatric AIDS Initiative was launched by NACO and the Clinton Foundation in 2006. The primary goal of the Pediatric Initiative, under NACP, is to provide prevention, care and treatment services for children infected or affected by HIV/AIDS. Targets include providing ARTs to at least 40,000 children living with AIDS by 2011. In 2006, NACO pioneered the use of pediatric fixed dose combination (FDC) formulations for children. India was the first country to procure and distribute Stavudine-based FDC formulations for children. The National Pediatric AIDS Initiative made pediatric formulated fixed dose combination drugs available and simplified daily medications for children. Pediatric ARVs are available in 217 NACO supported ART centers. Second line pediatric ARVs are being procured by the Clinton Foundation. The first line Pediatric ARV drugs are procured by NACO through Clinton Foundation and Global Fund. The National Guidelines for HIV Care and Treatment in Infants and Children developed in 2006 are based on the WHO 2006 guidelines for ART in infants and children in resource limited settings. CTX prophylaxis is included as a standard of care for all HIV-exposed infants from 4_6 weeks of age (or at first encounter with health services) until HIV infection can be excluded, all HIV-infected infants less than one year of age irrespective of symptoms or CD4 counts, and for all HIV-infected children between one and five years of age. The ART initiation for children is guided by the CD4 percentage and the age of the child per the national guidelines. CD4 counts are done free of cost in more than 150 CD4 centers. Viral load testing is not available in most settings. NACO is working with the Clinton Foundation to implement a computerized patient record system at the centers to track pediatric and adult HIV patients. There is currently one functional Pediatric Center of Excellence (COE) in Delhi. Seven additional ART Centers, in high-prevalence states, are being upgraded as COE to provide comprehensive specialized services to children living with HIV and be nodal points for research in pediatric care. The HIV pediatric care network will be extended to Community Care Centers (CCC) to provide services to promote the health, growth and development of children infected by HIV/AIDS in

districts where MTCT of HIV is especially high. NACO and WHO developed the Pediatric ARV Counseling Manual for ART counselors to ensure pediatric ARV drug adherence. However pediatric counselor training has not been scaled up by NACO. Accomplishments since last COP The USG provided technical assistance (TA) for developing the National Infant HIV testing Algorithm/Guidelines and the infant feeding guidelines for HIV- exposed infants. USG-funded programs in Tamil Nadu (TN), Karnataka, Maharashtra and Andhra Pradesh (AP) contributed significantly to the identification, care and treatment, support, referral and follow-up of pediatric HIV cases. The USG piloted integration of pediatric HIV services into existing programs. In Karnataka the USG partner supported the Link Workers program that facilitated outreach activities for identification, early diagnosis, referral and follow-up of children living with HIV in rural communities. USG successfully integrated HIV training into the WHO developed Integrated Management of Neonatal and Childhood Illness (IMNCI) curriculum in coordination with the Department of National Rural Health Mission (NRHM) in the state of Karnataka. The outcome of this training has resulted in a resource pool of HIV- trained service providers across 12 HIV high prevalence districts in the state. In Tamil Nadu, USG partner supported clinical trainings for health care providers, especially medical officers and nurses, specializing in pediatric care and treatment, including laboratory support for infant diagnosis. USG FY10 and FY11 Support USG support for pediatric care and treatment will continue to be aligned with NACO needs of early identification of HIV infected children. The USG will provide TA to NACO for implementation of the EID guidelines to identify HIV positive infants and initiation of ARVs as early as possible to reduce the infant morbidity and mortality due to HIV/AIDS. The USG along with UNICEF will continue to provide TA to NACO on Pediatric care and treatment at the national level. USG support to direct interventions at the state level will be used primarily as a platform for demonstration of best practices for ensuring referral and linkages with the pediatric ART centers and providing pediatric ARV adherence counseling. The USG will provide TA to NACO to continue commitment to integration of pediatric HIV care and treatment into routine clinical services. Integrated services will help ensure pediatric HIV care and treatment, sustainability and improved coverage. As an active member of the National OVC Task Force Group (that provides technical assis tance to NACO on issues related to Children and HIV) USG will continue coordination and integration efforts at the national level to ensure access to health, education and social support services for HIV infected children. The USG and the Clinton Foundation will promote and facilitate integration through behavior change with and training of pediatricians, general physicians and nurses. USG will continue to provide support to NACO in establishing the seven pediatric COE. These COE will provide specialized laboratory services, including EID, second line ART, patient care for management of Opportunistic Infections, ART adherence counseling, nutrition support and counseling services for HIV positive adolescents and their parents /families. Based on previous pilots, the USG will develop learning sites for home and community based care for HIV infected and affected children through USG - supported programs. These sites will be demonstration projects for provision of quality care and support services for infected and affected children with HIV. Results from the demonstration projects will be reported to NACO and used to further develop a NACP Pediatric HIV/AIDS service scale-up. USG partners will continue to provide TA to the State AIDS Control Societies to ensure integration of pediatric HIV care services with the NRHM to reduce infant and maternal morbidity and mortality by ensuring universal access to MCH services. Emphasis will be on coordinating combined child health and pediatric HIV care trainings for different cadres of health care at state and district level. USG partners will continue to provide TA to the implementing partners on home and community based care and support to ensure integration of HIV services and child survival interventions into existing services. The key areas of quality improvement will include adherence to long term ART, early identification of children living with HIV, child counseling, ARV treatment literacy for family members and care givers, community engagement, nutrition support and counseling, good home care advice for common illness symptoms such as fever, diarrhea, cough, skin problems and sore mouth. Ensuring access to a basic care package for all the HIV positive children identified at the district will be a strong focus for implementing partners this year.

Technical Area: PMTCT

Budget Code	Budget Code Planned Amount	On Hold Amount
MTCT	675,351	
Total Technical Area Planned Funding:	**675,351**	**0**

Summary:
Context and Background India is the second most populous country in the world and has 2.31 million people living with HIV, women account for 39% of this population. With a national HIV prevalence of 0.34%, India continues to have a concentrated epidemic. The national prevalence of HIV among pregnant women attending antenatal clinics (ANC) is 0.48%. The ANC prevalence is declining in the southern and northeastern states while the states of Gujarat, Rajasthan, Orissa and West Bengal show a rising trend. Nearly 200 HIV high-burden districts (out of 600 nationwide) report ANC HIV prevalence greater than 1%. Given that there are an estimated 27 million deliveries annually in India, an estimated 85,000 infected women become pregnant and give birth to 25,000 infected babies each year. Mother to child transmission is the most significant route of HIV transmission in children below 15 years in India and accounts for 4.3% of HIV transmission. Despite the Government of India_s National Rural Health Mission (NRHM) program, only 50.7% women access ANC services, 40% have institutional deliveries, and 36.4% women have access to post natal care services. The National AIDS Control Program Phase III (NACP III) is committed to provide Prevention of Mother to Child Transmission (PMTCT) of HIV services to 7.5 million pregnant mothers annually and prophylaxis to 75,600 HIV-positive mothers through 4,955 PMTCT centers by 2012. NACP III is in the process of integrating PMTCT services with the NRHM, especially with the Maternal and Child Health (MCH) program by 2015. HIV testing for emergency room labor cases is being considered by NACO to increase uptake of PMTCT services in the public sector. UNICEF is the key technical partner for the national PMTCT program. The Government of India_s (GOI) PMTCT program (2002) is based on single dose Nevirapine (SD NVP) and focuses on antenatal care as an entry point for PMTCT services. Under NACP III, HIV testing facilities for pregnant women are currently available at 4,817 centers in tertiary, secondary and in some primary health care centers, across the 200 HIV high burden districts. National AIDS Control Organization (NACO) is planning to introduce Early Infant Diagnosis (EID) in the identified 10 Centers of Excellence (COE) in the first phase with plans to scale up the EID facilities in the next one year. In addition, the first phase of EID introduction in the PMTCT program will provide for transporting of dried blood samples from all the designated PMTCT sites to the nearest COE. The National PMTCT Working Group, which includes NACO, UNICEF, Clinton Foundation, WHO and USG, developed the guidelines and training modules for program implementation, monitoring and evaluation and quality assurance. The national program has revised its guidelines for initiating antiretroviral therapy (ART) for eligible pregnant women with the objective of decreasing pediatric infections and assuring linkages to care and treatment. HIV positive pregnant women with a CD4 count of less than 350 cells/cmm will be referred for ART. Women with CD4 Count more than 350cells/cmm will be given prophylactic SD NVP at the time of labor /delivery along with the SDNVP syrup for the newborn. There has been a directive from NACO to all the states for ensuring CD4 count tests are done for all the identified HIV positive pregnant women. Currently CD4 testing is available at 152 centers in the identified districts. The Global Fund Round 2 and the Rolling Continuing Channel Round 2, funds the national PMTCT program which includes counseling and testing of pregnant women in the antenatal clinics, identification of HIV positive pregnant women, institutional delivery, and enrollment for prophylactic SD NVP for mother and baby, infant feeding counseling and support, nutritional counseling for mother, follow up and linkage with the care and support program. Despite the existence of a national PMTCT program, the scale up of PMTCT services has been a challenge. In 2008, 4.15 million pregnant women (15.4% of all pregnancies) received PMTCT services in 4,817 sites and 19,986 women tested HIV positive. However the PMTCT intervention cascade services are available at only 2,800 functional sites which translates to poor completion of the PMTCT cascade with only 51% of the identified mother -baby pairs receiving SD NVP in 2008. The poor coverage of the PMTCT services is primarily due to the fact

that 60% of deliveries occur at home without access to SD NVP. Women traditionally return to their mother_s house for labor and delivery and there is overall low uptake of antenatal and delivery care due to financial, geographical and socio cultural barriers. Stigma, fear of receiving an HIV positive test, lack of confidentiality and limited male involvement remain significant barriers to providing the PMTCT cascade services. Evidence shows that the negative consequences of disclosure are more frequent for pregnant women as the fear of abuse is a possible consequence of being diagnosed HIV positive. The private medical sector caters to 50% of the total institutional deliveries in India and has not been fully engaged by NACO. The Federation of Obstetricians and Gynecologists of India (FOGSI) is a 25,000 strong membership that provides maternal and child health services in the private sector. FOGSI has a great role to play in the implementation PMTCT services in the private medical sector. Accomplishments since last COP The USG, an active member of India_s National PMTCT Working Group, has been actively involved in developing the Early Infant Diagnosis guidelines for the national program, adopting the AZT cover tail PMTCT protocol and revising the PMTCT guidelines for initiation of ART in pregnant women with CD4 count less 350cells/cmm. The USG has provided Technical Assistance (TA) to NACO for developing the Infant feeding guidelines for HIV infected women with an emphasis on exclusive breastfeeding for the first six months of life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe for them and their infants before that time. The USG has established effective collaborations with FOGSI, UNICEF and NACO to develop the PMTCT guidelines for the private medical sector. In addition, the USG supports the National Program Officer at NACO to strengthen the national team for PMTCT scale up and service delivery. To ensure the integration of MCH interventions with HIV programming USG is an active member of the Technical Working Group of NRHM and NACP convergence which has members from Ministry of Health and Family Welfare, UNICEF, World Bank, DFID, GTZ and other donors. This technical group provides ongoing TA to NACO and NRHM to facilitate the process of integration at the state and district levels. USG-funded programs in Tamil Nadu (TN), Karnataka, Maharashtra and Andhra Pradesh (AP) have contributed significantly to raising the demand for and utilization of PMTCT in the private sector where half of all institutional deliveries occur. USG partners also support the private medical sector to provide PMTCT services at three locations. Intensive training has been conducted for the health care providers of these PMTCT sites to ensure quality PMTCT cascade interventions are available to the beneficiaries. Currently, the three PMTCT sites in the private sector are being assessed by an external team of consultants. The findings and recommendations of this assessment will be shared with NACO to assist the scale up of PMTCT service delivery in the private medical sector at state and district level. USG FY10 and FY11 Support In FY10, USG support of PMTCT will continue to be aligned with NACO_s need of engaging the private medical sector in the provision of a PMTCT cascade of interventions. USG support to direct PMTCT services in private sector hospitals will use primarily as a platform for using successful models that NACO will replicate and scale-up. The USG acti vities will focus on TA that will enhance strategies to increase acceptance of antenatal services, integrate PMTCT and MCH services. The USG will continue to support the National Program Officer to lead PMTCT activities at the national level. As PMTCT coverage also depends on the extent of integration with the NRHM that provides MCH services at state and district level, USG will continue to play an active role as a member of the NRHM and NACPIII Convergence Technical Working Group. Recognizing the importance of implementing the highly effective multidrug prophylaxis regimen, the USG will continue to advocate for revision of the SDNVP regime at the national level. The USG will work closely with FOGSI and UNICEF to finalize the standardized PMTCT guidelines for private sector hospitals. TA will support: the adoption of standardized protocols for treatment and patient management; strengthening follow-up for mother-baby pairs; multidrug prophylaxis promotion; patient records maintenance; and reporting and costing guidelines in the private medical sector. USG partners in the states of Karnataka, Maharashtra, AP and TN will strengthen the linkages between the NRHM and the PMTCT cascade interventions. Emphasis will be laid on integrating PMTCT training in the training agenda of the Safe Motherhood and Child Survival planned state and district level programs. At the state level, USG partners will strengthen the PMTCT integration with ART as well as Care and Support and OVC services by ensuring capacity building of the health capacity of the implementing partner project staff. For ensuring sustainability of the PMTCT intervention, ongoing Link Worker schemes (community-

based outreach) and other existing infrastructures and services at the district level will be utilized to increase the uptake of PMTCT cascade services. PMTCT centers will use the existing link workers (community level workers) to conduct community mobilization and ensure safe and effective services are accessible to most at-risk populations. The link workers will also target men as supportive partners to encourage testing and disclosure, follow-up of mother and child, and support for treatment. Link workers will also foster PMTCT, Care and Support, and Treatment programs to ensure that women and children are enrolled in programs and the women benefit from improved patient tracking, follow-up and provision of comprehensive HIV care.

Technical Area: Sexual Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
HVAB	584,362	
HVOP	3,905,617	
Total Technical Area Planned Funding:	**4,489,979**	**0**

Summary:
Context and Background India, with an estimated 2.31 million individuals infected with HIV, has the third largest epidemic in the world. India continues to have a concentrated epidemic with adult HIV prevalence of 0.34%. Prevalence among men is higher compared to women, with 1.6 men infected for every woman infected with HIV. Women and children constitute 45% of the total population infected. HIV prevalence is highest among most-at-risk populations (MARPs), particularly in the highest prevalence states in southern and north-east India. An estimated 5% of female sex workers (FSW) and 7.4% of men having sex with men (MSM) are infected with HIV. The National AIDS Control Organization (NACO) has also prioritized truckers and migrants as bridge populations for HIV interventions. The prevalence among migrants (3.6%), truckers (2.4%) and STI clinic patients (3.6%) is estimated to be almost eight to ten times the adult population prevalence. The national HIV prevalence masks the wide variation in state and district-level epidemics. There are several states and districts where prevalence appears to be rising. A third of FSW sentinel sites have >5% prevalence, with the highest rates in Mumbai (42%) and Pune (59%). Similarly 50% of MSM sentinel sites have >5% prevalence. The third Indian National AIDS Control Program (NACP III) emphasizes prevention among MARPs. Nearly 67% of NACP III resources are earmarked for prevention activities. The State AIDS Control Societies (SACS) have responsibility for implementing NACP _III at the state level. The government has asked several donors including the USG to establish Technical Support Units (TSU) to strengthen the capacity of SACS, with priority to strengthening Targeted Interventions (TIs) for MARPs. The NACP-III prevention strategies include: a) saturating coverage of MARPs in urban and high-concentration areas through TIs; b) implementing the Link Worker Program (Link Workers are volunteers focused on reaching MARPs, vulnerable populations and people living with HIV/AIDS (PLHIV) in rural areas to promote prevention, care, support and treatment services);, c) initiating interventions for short-stay single male migrants and long-distance truck drivers through NGOs and mainstreaming with relevant ministries; d) focusing on programs for women and youth, and; e) increasing access to male and female condoms, Sexually Transmitted Infections (STI) treatment and counseling and testing services. NACO provides condoms free of charge to USG-supported projects. The USG collaborates with social marketing organizations to increase access of male and female condoms to target communities. Over the last year there have been several important developments and achievements with regard to sexual prevention. Notable among them are: a) The historic judgment, by the Delhi High Court legalizing consensual adult male homosexual relations overturning the Indian Penal Code Section 377. This change in the legal code is widely seen as an important step to create a more enabling environment for programs seeking to reach marginalized MSM

with HIV services. b) The initiation of the Mid-Term Review (MTR) of NACP-III programs. The MTR is a coordinated effort by NACO, and development partners to assess the progress of NACP-III against plans; provide insight on factors facilitating / hindering progress; ascertain effectiveness of technical strategies; and review resource commitments and gaps. c) Scale-up of TI and Link workers program. Nationally 1513 TI projects were contracted, an increase of almost 80% from last year. NACO also rolled-out the Link Worker Program in 90 out of 187 high HIV prevalence districts. USG prime partners in TN and Maharashtra have leveraged resources from NACO to implement the Link Worker program in all high-prevalence districts. USG programs coordinate with NACO, multilateral agencies and other international donors to influence national policy and provide technical assis tance (TA). At the state level, USG partners coordinate with local State AIDS Control Societies (SACS) and other developmental agencies to share data, best practices and support joint initiatives. The USG and the Bill and Melinda Gates Foundation (BMGF) are the two major agencies supporting programs among MARPs and bridge populations. UNICEF, the United Nations Development Program (UNDP) and Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) support HIV/AIDS programs for youth, industrial workers and human trafficking issues. USG programs continue to leverage millions of dollars for condoms, STI drugs and HIV test kits from the state governments for its programs. They also coordinate with local ministries to link MARPs with existing social and development programs offered by the state and central government. USG accomplishments since last COP: In line with NACP III and PEPFAR II priorities, the USG increased the amount of TA through a mix of technical expertise and capacity building for NACO and SACS to manage MARP interventions and demonstration projects. At the national level, the USG provided technical expertise in the development of the terms of reference for the NACP-III MTR, including defining thirteen assessments for review. The MTR recommendations are expected in November, 2009. USG is the NACO-designated TA lead for standardizing the Behavioral Surveillance Survey (BSS) tools for MARPs and other risk populations. The USG also provided TA to NACO for developing the operational guidelines for state-level data triangulation and is a member of the Advisory Group to assess impact of TI programs. The USG team also provided technical expertise during joint implementation reviews, donor coordination meetings and provided critical inputs to strengthen prevention efforts. The USG staff and prime partners served as members in several national and state technical working groups (TWG) including migrant interventions, positive prevention for PLHIV, condom social marketing, and is the vice-chair for the TI Technical Working Group. The USG prime partners provided TA to NACO to review programs supported by other donors. Recently, the USG participated in a review of BMGF prevention programs and provided guidance to NACO on transitioning BMGF projects to state programs. The USG supported six Technical Support Units (TSU) (managed by prime partners) provided TA to SACS across seven high prevalence states. The primary focus of the TSUs is to scale-up TIs for MARP and other risk populations; strengthen SACS capacity on strategic planning; mainstreaming and public-private partnerships; and assist in integrating HIV/AIDS programming into other relevant ministries ensuring greater local ownership of these services. These TSUs played a critical role in scaling up interventions. In TN, a USG prime partner also supported a three-member strategic information support team strengthening TI data analysis, data quality assurance and for supporting evidence-based TI programs. A USG prime partner also provided technical expertise to TANSACS for an STI prevalence survey among MARPs in addition to analyzing the changing dynamics of sex work. The assessment will provide FSW population estimates and detail current prevention practices among non-brothel and non-street based sex workers in TN. Based on NACO_s request, USG prime partners supported the mapping of MARPs in TN, Kerala and Uttar Pradesh. The mapping results helped the states to get a better estimate of MARPs and to plan and prioritize interventions. Additionally, in selected districts of TN, Maharashtra and Karnataka, USG partners supported NGOs for saturating coverage of MARPs and demonstrated models of prevention-to-care-continuum. Nearly 15% of MARPs in these three states were reached through USG prime partners. USG programs also pioneered the concept of positive-prevention, where NGOs engaged in prevention followed-up with HIV positive MARPs for positive prevention, follow-up counseling and social support. This is a p otentially cost-effective approach and improved access to critical prevention and treatment services among HIV positive MARPs facing double-stigma. Several USG innovations developed through demonstration projects were adopted in India. In Karnataka, USG partners pioneered

the concept of reaching rural MARP through Link Workers, a model now recognized by NACO and scaled up nationally through the support of the Global Fund. The Karnataka program was used as a Link Worker learning site for other states. Communication materials developed by USG partners for MARPs and bridge populations have also been adapted by SACS and NACO. Additionally, a risk-assessment tool developed by a USG partner in Andhra Pradesh for prioritizing industries based on risk is now being used by other agencies. The USG and prime partners are increasingly engaged in supporting strategic and technical assistance activities and gradually moving away from direct implementation of programs. USG prime partners are engaged in discussions with SACS for transitioning its TI projects in a phased manner to SACS, so that emphasis for TA and strategic support can be further enhanced. The USG India Prevention Technical Working Group has also been constituted with a primary mandate to provide TA to partners and promote best practices to SACS and NACO. Many challenges still persist: a) Coverage: national service coverage among MARP is below the goal of 85%. Only 53% of an estimated 1.26 million FSWs and 77% of an estimated 0.35 million MSMs are reached through interventions. Reaching MARPs in rural areas, interventions with spouses and regular partners, and early identification of, and outreach to, young and new sex workers continue to be a challenge. b) Comprehensive package of services: Current interventions with MARPs primarily focus on condom promotion, although other essential risk reduction component options include: positive-prevention counseling (including the reduction of the number of sexual partners); increasing access to STI treatment, HIV counseling and testing; care, support and treatment services. Similarly, working with children of FSWs to prevent second-generation sex work, alternate livelihood options for FSWs (particularly for those who are infected), addressing alcohol and drug abuse among MARPs, and addressing structural issues are critical components in prevention programs but currently are not getting the required emphasis. c) Quality of programs: The BSS 2006, data points to several gaps and need for focusing on quality. Correct knowledge of HIV, timely treatment-seeking behavior and consistent condom use among MARPs continue to be areas for improvement. There is little data on the number of MARPs accessing counseling and testing, care, support and treatment services or on the quality of these services. This information is critical to improve access to services for heavily stigmatized MARPs and PLHIV. USG FY10 and FY11 Support The overall USG sexual prevention strategy is to support the national plan of saturating coverage of MARPs and other vulnerable populations with a combination of implementation and technical assistance support. The USG will work with NACO and SACS to address TI gaps and improve the quality and scale of programs. 1. Support to national and state TSUs: USG partners will continue to provide TA to national and state TSUs for effective roll-out of prevention programs. The TSUs will coordinate with NACO and local SACS to identify gaps in prevention and establish benchmarks on scale-up and quality. USG partners will strengthen the capacity of District AIDS Prevention and Control Units to plan, roll-out and monitor HIV prevention programs at the district level. The USG will also work with NACO to identify capable institutions to ensure that capacity building of SACS is institutionalized and USG support to TSUs can be withdrawn in a phased manner. The USG will support NACO and SACS to implement the recommendations of the MTR, participat e in Joint Implementation Reviews and provide technical and strategic inputs to improve the quality and effectiveness of prevention and care programs. The USG and its prime partners will also participate in procurement committees and assist NACO and SACS in developing appropriate policies, guidelines and systems. 2. Learning sites and documenting best practices: The USG will promote the documentation and dissemination of best practices. The USG will partner with NACO, SACS, TSUs and implementing partners to support awareness and flexible models for implementation. In selected high-prevalence districts, the USG will continue to support prevention-to-care continuum demonstration models. The models will saturate coverage, offer comprehensive services, establish strong linkages and follow-up with MARP to access counseling and testing, care, support, and treatment services. In Maharashtra, the USG will support demonstration models for male migrant interventions, strengthened by TA at the national level. 3. Integrating gender in prevention programs: USG-supported programs will undertake a gender assessment covering the five areas: sexual violence, equitable services, addressing male norms, increasing women_s legal rights and access to income. USG partners will address the five cross-cutting gender strategic areas through capacity building of NGO staff and addressing structural issues. Data will also be disaggregated by gender and analyzed to better

understand gender dynamics related to sexual prevention. 4. Modeling and other assessments relating to MARPs: There are still several gaps in information about MARPs. For example there is limited information on the mobility patterns of MARPs, changing dynamics of sex work for FSWs, and barriers faced by MARPs for accessing counseling and testing, care and treatment services. The USG, with SACS and NACO, will identify priority areas for assessments. 5. Transition of USG-supported TI projects: The USG and prime partners will coordinate with NACO and SACS to develop a phased transition of TI projects and direct implementation activities to SACS, thereby ensuring sustainability of coverage and services. A transition working group with representation from the USG, prime partners, SACS and NACO will be established to oversee the transition of projects to SACS. The transition working group will also assess effectiveness and quality of coverage after the transitioning and provide guidance to prime partners and SACS. 6. Positive Prevention: Reaching out to HIV positive MARPs with positive prevention services is critical. The counseling and service needs for MARPs are different from the PLHIVs. The USG will do an assessment of MARP and PLHIVs and develop a comprehensive positive prevention program targeting MARPs. Existing successful modules will then be adopted by NGOs and positive networks.

Technical Area: Strategic Information

Budget Code	Budget Code Planned Amount	On Hold Amount
HVSI	3,517,683	
Total Technical Area Planned Funding:	**3,517,683**	**0**

Summary:
Context and Background Strategic information (SI) includes monitoring and evaluation (M&E), surveillance, research, and management information systems. SI was included as one of the four overarching objectives of the third National AIDS Control Program (NACP-III) which runs from 2007-2012 with 3% of the total $2.5 billion budget dedicated to SI. A central theme of NACP III is the decentralization of data collection and data use to the state and district level. Strategic Information Management Units (SIMU) at the national and state level bring together M&E, surveillance, and operational research under one roof. A National Technical Support Unit (TSU) has been established to oversee the work of all the state level TSUs that serve as the policy implementation and strategic planning bodies for the State AIDS Control Societies (SACS). Together, these bodies provide oversight to the District AIDS Prevention and Control Units (DAPCUs) - district level administration units for coordinating HIV program implementation. The national government has many systems in place to track the state of the epidemic. The third National Family Health Survey (NFHS III) was the first population-based HIV prevalence survey in India, to which USG was a major contributor in providing TA and leveraging donor support. This household survey was a major leap towards validating HIV prevalence rates in India and focusing HIV programs. The next NFHS is planned for FY 2010. Mapping exercises and estimation activities have been completed among high risk groups. NACO uses HIV sero-surveillance for different populations in 1,134 sentinel sites, a periodic national behavioral surveillance survey in a sample of general and high-risk populations, AIDS case reporting from all states, and surveillance for STIs from more than 900 facilities across the country. The number of sentinel surveillance sites increased from 320 in 2001 to 1134 in 2008, including 646 antenatal clinic (ANC) sites, 137 female sex worker (FSW) sites, 52 IDU and 40 MSM sites. A big technological advancement was the introduction of dried blood testing (DBS) for the most recent round of sentinel surveillance. Informed consent was also introduced as part of the methodology of sample collection at Most-at-risk populations (MARP) sites. Data from surveillance are used to classify India_s 611 districts into 4 epidemic categories: A,B,C and D, with priority given to the A and B category districts. In terms of the national government_s response to the epidemic, there are many sources that continue to provide routine programmatic data to improve service delivery and programs. The national computerized management information system (CMIS), started in the 1990s to

generate monthly and annual reports from service delivery information collected at state and district levels has over 8,500 primary reporting units. It provides a fairly representative picture of the government_s response to the epidemic in India. It has been recently evaluated and is undergoing a transformation, with a renewed emphasis on monitoring for results, ability to facilitate tracking of Global Fund inputs, capturing PLHIV data from smart cards and interfacing with other financial and contractual data systems at NACO. Infrastructural improvements are being effected through upgradation of computers and net-connectivity. State epidemiologists and M&E officers are being hired to fill gaps in staffing. Training and capacity-building plans for these officers are underway to encourage decentralized data collection and use. The national ART MIS, which is a separate system from the CMIS, is a very effective tool for tracking ART-related information. It provides a comprehensive status of all aspects of the NACO treatment program, from drug procurement, to dispensation, adherence and other clinical markers. Some underlying SI challenges, however, still remain. Data is still largely public-sector oriented, since data from the majority of the priv ate sector providers does not flow into the CMIS. Data quality and utilization is an issue at all levels. While the completeness and accuracy of various information systems is improving, utilization of generated data is limited. The capacity to utilize SI varies widely by states. In addition, the recent release of data sharing guidelines, specifying data at national, state or district level cannot be shared with external/non-governmental stakeholders unless a written request is processed and permission sought at the highest level of NACO leadership, has added an additional layer of complexity to data access. The guidelines are a deterrence to data use and analysis. Scientific writing is still infrequent and sporadic, and not enough analysis is published in international forums. Qualitative research has not found its due importance and despite the presence of social scientists, not enough qualitative research is taking place to compliment the quantitative research which is the main focus of the national government. Despite these challenges, NACO prioritized the use of SI for assessing program outcomes and took a critical look at its interventions. In 2009, NACO evaluated several of its program strategies. The TSUs, placed alongside the SACS as the think tanks for targeted interventions among MARPS, and targeted interventions for MARPS were evaluated. Several non-performing TSUs were closed down and those that were performing well were encouraged to provide support to other states. The Joint Implementation Review (JIR) of NACP III interventions, conducted every 6 months by the World Bank and Department for International Development (DFID), supported by the entire development community, including USG, Bill and Melinda Gates Foundation (BMGF) and other donors, was conducted in the states of Madhya Pradesh, Andhra Pradesh, Gujarat, West Bengal, Assam, and Maharashtra. NACO fully cooperated with the two JIRs and ensured that a critical view was taken of all areas that were found to be wanting. Corrective action steps were undertaken and a written response to each recommendation was provided. NACO_s commitment to make mid-course corrections based on strategic information is evident from its determination and fervor in carrying out the mid-term review (MTR) of the NACP III. All NACO staff and the entire donor community have been mobilized to participate in the review and USG has been identified as a lead in the evaluation of many of NACP III_s components. The previously mentioned triangulation exercise is also a part of this review. The MTR data, along with data that has been complied over the past few years from surveillance, special studies, monthly-generated Prevention of Parent to Child Transmission reports, reports from counseling and testing centers, program assessments, MARPs mapping, private service provider mapping, biological and behavioral surveillance among MARPS, and the NFHS will be used to come up with a more sound district classification methodology rather than just basing the categorization on the annual sentinel surveillance, which comes with its own set of biases. This will help focus attention on the real _hot spots_ rather than many districts that tend to get highlighted due to sample irregularities and erroneous data quality. Accomplishments since last COP USG has been identified as a technical resource for the national government in spearheading its SI initiatives.The most significant achievement since last year has been acknowledgement by the national government that USG is one of the leading strategic information resources for evidence-based planning. The hallmark of USG TA in the area of SI has been utilization of various data sources at the district level and eventually at the state level, in order to prepare district and state action plans. In Andhra Pradesh and Maharashtra, USG took the lead in preparing district profiles that encapsulated all vital HIV and demographical statistics, service provision and access details and gaps that exist in the continuum of prevention to care services.

An important component of USG SI support is health management information systems. USG continues to provide intensive TA and resources to develop the TB/HIV information system (T/HIS) at the General Hospital for Thoracic Medicine (GHTM), Tamil Nadu, a hospital with the largest HIV and TB load in all of Asia. HIV specialists from the USG-funded ongoing HIV fellowship program at the hospital are using data from this system to carry out analysis in a host of technical areas particularly in care and treatment. However, it is important to note that most research so far has been focused on improving treatment and care services for patients being treated in GHTM. A special committee comprising GHTM, Tamil Nadu States AIDS Control Society, ITECH, CDC, National Institute of Epidemiology was initiated to expand use of T/HIS data to the larger public health arena. In addition to its work at GHTM, USG facilitated Geographical Information Systems (GIS) tracking of prevention programs in Tamil Nadu. With the rapid scale-up of community care centers (CCC), USG initiated an information system customized to the CCCs funded by the Global Fund, in Karnataka. As part of the Next Generation of Indicators (NGI) roll-out process, we engaged with NACO M&E program staff to gauge the alignment of USG indicators with the national reporting framework, in step with the Three Ones. NACO, while pointing deficiencies in the proposed framework also acknowledged the absence of some critical indicators in their own system, for example, indicators for laboratory quality assurance. This dialogue will continue well beyond this exercise. PEPFAR SI staff organized regional training on the NGI for all PEPFAR implementing partners. Through an exemplary coordinated effort, UNAIDS, WHO, Public Health Foundation of India , USG, Family Health International, Population Foundation of India and others prepared a comprehensive plan for NACO and SACS staff M&E capacity building in the areas of monitoring and evaluation, program management, and mentoring. Approval has just been granted. At the PEPFAR/India level, USAID, CDC, DOD and DOL undertook a strategic planning exercise, based on which program strategies were further refined and reworked. Many programs which were no longer aligned with the USG strategy in India were discontinued and there was renewed commitment from all Agencies to move towards a technical assistance model while consistently scaling down direct implementation activities. USG FY10 and FY11 Support All the proposed activities in the coming fiscal years are based on the comparative advantage that USG partners bring to the table. The USG has established a formidable SI reputation with NACO and SACS. With the national government placing an extraordinary level of importance of use of SI to focus on scaling up services under the NACP III, USG will provide strong support in the generation, analysis and utilization of data. USG will continue to take a leadership role in assisting with the NACP III MTR. Of the 8 states where data triangulation is being undertaken, USG will build capacity of local institutions in conducting data triangulation in 3 of those states. USG will also be a lead partner in implementing the BSS in 3 of the eight high prevalence states. As part of the MTR a USG prime partner is the prime technical resource for standardizing the BSS methodology across all states. USG is the lead in conducting a major financial status and expenditure analysis for the NACP III MTR. USG is a key partner in generating and analyzing strategic information for the MTR and the recommendations will guide mid-course corrections, implemented over the next several years. USG will continue to play a key role in the NACO staff M&E Training and Mentoring plan. FY 2009 was dedicated to planning and strategizing around the SI topics and identifying target audience for these trainings through needs assessments and stakeholder consultations. With the plan i n a concrete approved form, USG, in collaboration with other developmental partners, will build the skills of government staff in generation, collection, collation and most importantly, analysis of program and surveillance data. As part of advocacy efforts with NACO in the roll-out of the first comprehensive OVC pilot, USG will assist in the field testing of OVC indicator across India. T/HIS staff will be provided intensive training to ensure that data management and analysis, both are of superior quality and together aide program prioritization. USG will continue to provide crucial staff support at the national and state level, including epidemiologists, M&E officers, and program officers to ensure that the new strategic information management system has the right manpower to deal with the volume and complexity of data generated. USG will support the reconstituted national M&E Working Group to take up topical issues from the field, e.g. improving data quality and increasing M&E staff capacity. In some focus states, like Tamil Nadu, USG will help to convene a state-level M&E group that will regulate harmonized reporting from all partners. USG is discussing possible short-term TA on HIV prevalence estimates and projections, trend analysis and incidence analysis. USG will continue to support the

National TSU to strengthen their capacity to provide dedicated SI support to the state level TSUs.USG partners will continue to provide data analysis support for evidence-based planning through data analysis and capacity building exercises with local organizations to build their data analysis skills. Many USG partners plan to complete programmatic assessments of efficacy of many of their interventions with MARPS, PLHIVs, and other vulnerable populations. USG will train partners and sub-partners in the collection, management, analysis, and reporting of field-level data and PEPFAR will conduct a data quality assessment of partners_ data systems to validate protocols for data reporting. Recommendations from the assessment will be implemented to strengthen partner data quality and reporting systems. Through trainings, USG will strengthen the skills of new and current SI staff and in-country professionals on the three SI pillars (M&E, surveillance, and Health Managament Information Systems).

Technical Area: TB/HIV

Budget Code	Budget Code Planned Amount	On Hold Amount
HVTB	115,000	
Total Technical Area Planned Funding:	**115,000**	**0**

Summary:
Context and Background Background: India has 20% of the world_s tuberculosis cases (about 1.96 million cases annually), and over 131, 000 cases of multidrug resistant (MDR)-TB. The prevalence of TB is estimated to be approximately 3.8 million bacteriologically positive cases. The Government of India (GOI) supports a well-designed and implemented program for diagnosing and treating TB throughout the country. The Directly Observed Treatment Short Course Chemotherapy (DOTS) strategy was piloted and refined in India. Currently, the GOI_s Revised National TB Control Program (RNTCP) covers all of India through a network of approximately 12,000 microscopy centers and 120,000 DOTS centers. India has an adult HIV prevalence rate of 0.34% and an estimated 2.31 million people living with HIV. The estimated burden of HIV-TB co-infection is 0.9 million cases; between 1-13% of TB patients are co-infected with HIV depending on the setting. GOI TB-HIV integration activities started in 2001 to address high co-infection rates in six states with high prevalence of HIV: Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu. In 2004, the GOI extended these activities to eight additional states: Delhi, Gujarat, Himachal Pradesh, Kerala, Orissa, Punjab, Rajasthan and West Bengal. The National Framework for Joint TB-HIV Collaborative Activities was developed in February 2008 to further enhance collaboration between RNTCP and the National AIDS Control Organization (NACO) and reduce the burden of TB and HIV in India. The Framework includes five key points: establishment of coordination mechanisms at national, state and district levels; coordination of service delivery and cross-referrals through training of the staff and establishment of linkages between HIV and TB service delivery sites; involvement of NGOs working in NACP and RNTCP in TB/HIV collaborative activities; operational research to improve the implementation of TB/HIV collaborative activities.; and implementation of feasible and effective infection control measures. Activities supported by the Framework in 2008 resulted in a peak of 0.4 million cross referrals between TB and HIV programs and 25,603 individuals were diagnosed with HIV-TB co-infection. Coordination between RNTCP and NACO services has been challenging for multiple reasons. Previously, HIV and TB services were not routinely co-located. HIV services are provided mostly at the district level (each district has a population of approximately 2 million) in district hospitals, while TB services are provided in villages at the sub-district level. Previously, TB testing was not readily available in HIV care settings. TB providers actively resisted accepting patients referred from HIV programs for DOTS due to concerns that HIV stigma and discrimination would extend to TB programs, as well as the fact that they lacked the capacity to provide HIV services. The challenges were outweighed by the advantages of co-locating TB and HIV programs to improve treatment of both infections. GOI used funding from Global Fund for AIDS, TB and Malaria (GFATM) Round 3 to co-locate

329 TB microscopy centers in Integrated Counseling and Testing Centers (ICTCs) in high HIV prevalence districts. In October 2008, the intensified HIV/TB package of services was rolled out in 156 districts in nine high HIV prevalence states with a population of more than 320 million. This resulted in a seven fold increase in the detection of TB cases at ICTCs. GOI is now scaling up this important initiative in over 200 high HIV burden districts all over the country. Co-trimoxazole, for preventive treatment of patients co-infected with HIV and TB, has been added as a pilot initiative in DOT centers in three districts of Andhra Pradesh (AP), where there is a system for sharing information between the HIV and TB programs under a joint agreement for "shared confidentiality_. In this principle of shared confidentiality, the HIV status of the individual is shared with the TB D OTS center after obtaining explicit approval from patient for the purposes of providing co-trimoxazole prophylaxis and monitoring for TB. The national government currently does not support Isoniazid TB prophylaxis for people living with HIV (PLHIV). The high burden of TB infection in India, i.e. around 40%, creates problems for ruling out active TB in HIV patients. And operationally, the cost of such an endeavor is higher than treating the patient with a complete course of anti TB drugs. However, not withstanding this, the GOI is conducting ongoing clinical trials to evaluate its effectiveness at the Tuberculosis Research Center of the Indian Council for Medical Research in Chennai. Accomplishments since last COP: Effective delivery of TB-HIV services depends on strong linkages between the NACO and RNTCP. USG PEPFAR, other USG health sector support to the TB Control Program, and an advisor at WHO, funded with non-PEPFAR TB funds, have fostered and supported these linkages on an ongoing basis through technical and resource support at all levels, especially at the national level and in the high-prevalence states of Tamil Nadu, Andhra Pradesh, Karnataka, Maharashtra, Manipur and Nagaland. USG PEPFAR has worked with the USAID TB Control activities in Karnataka to strengthen the TB-HIV referral complex to ensure treatment adherence for both TB and ART through a comprehensive care, support and treatment program in 15 districts. Similar efforts are ongoing in five coastal districts of AP as well. The USG provided technical assistance to revise the TB-HIV providers_ curriculum to improve treatment in both national programs. The USG-supported WHO technical advisor provides critical policy and technical inputs on TB-HIV issues at the national level. This advisor has worked closely with the GOI on policy development and program implementation, especially in the areas of TB/HIV surveillance, provider-initiated counseling and testing, and TB/HIV coordination. The USG, along with DFID, World Bank and WHO were involved in a series of Joint Monitoring Missions (JMM) to review progress in the implementation of the India Revised National Tuberculosis Control Program (RNTCP) and TB-HIV collaborative initiatives. Provider-initiated HIV counseling and testing (_opt out_), especially for patients with TB, is a priority in the third National AIDS Control Program (NACP-III). GOI piloted provider-initiated HIV testing of TB patients in April 2007 in two districts. The positive results led to a major change in national policy on _opt out_ testing and paved the way for scaling up _opt out_ testing by all TB providers. The USG has helped in scaling up this initiative across all PEPFAR-funded USAID-funded TB projects and supported areas during the last year. In 2009, USG PEPFAR also supported a demonstration project providing mobile counseling and testing vans in remote rural areas for follow up of DOTS treatment for co-infected persons. Counselors from various USG-supported projects have supported government DOTS centers to ensure smooth referrals and counseling of TB-HIV patients. The USG also developed the capacity of a wide range of health providers in HIV programs, including counselors, peer educators, HIV-positive network persons and men who have sex with men, to serve as DOTS providers. USG FY10 and FY11 Support USG technical assistance in TB-HIV coordination is accomplished through close collaboration between USG PEPFAR, USAID, WHO, and GFATM, and involves minimal PEPFAR funding. During FY10, the USG will continue to provide TA for further consolidation of HIV-TB collaborative services and scale up of successful models for such services. Support at national level: _ All USG-supported HIV/AIDS care and treatment programs will continue to implement systems to screen for TB and refer patients for DOTS treatment. Community and home-based care programs will consolidate linkages with local RNTCP clinics and, wherever feasible, become DOTS providers. The drop-in centers in the care and support projects for PLHIVs in Pune and Salem, are already acting as DOTS centers in the community. The DOTS program at Government Hospital for Thoracic Medicine Tambaram (GHTM) will be enhanced and monitored and the lessons learned about program integration will be shared nationally. _ The USG will use staff HIV-TB technical

expertise to support strong links between the TB and HIV programs nationally and in the USG focus states. The USG will continue to support the WHO technical advisor. _ The USG will provide TA for scaling up provider-initiated counseling and testing (PICT) for TB patients in all USG-supported states. _ USG technical support will be provided to assist the RNTCP in revising the national TB infection control guidelines, integrating TB-HIV coordination principles into training programs and developing an action plan for roll-out of the guidelines and training with a realistic implementation timeline. Support at state and district level: _ The USG will propose four Community Care Centers (CCCs) (three in Karnataka and one in coastal AP) as Designated Microscopy Centers (DMCs) under the RNTCP public-private partnership scheme to improve access to TB diagnosis and treatment of PLHIVs. _ Increasingly, the GOI is decentralizing HIV program implementation to the district level and establishing District AIDS Prevention and Control Units (DAPCU) in all high burden districts in India. The USG will work with SACS to advocate for and facilitate placement of district level TB-HIV Coordination Committees to improve linkages between ICTCs and DMCs in USG focus states of AP, Tamil Nadu, Karnataka and Maharashtra. _ In Tamil Nadu, a collaborative partnership with the private sector covering 20 private hospitals will treat TB-HIV patients. Counselors in the hospitals will refer patients between the TB and HIV programs for HIV and TB testing. Institute of Road Transport IRT Perundurai Medical College will be engaged in treating HIV-TB cases at this institution and 65 private hospitals labeled as Nakshatra Clinics. In Andhra Pradesh, The USG will support the development of workplace policies for TB-infected and HIV-positive employees to reduce stigma and discrimination. In Karnataka and AP, USG programs will strengthen linkages for TB referral and treatment in private sector workplace programs by collaborating with the Employee State Insurance Corporation (a parastatal organization providing health services) and empanelled hospitals.

Technical Area Summary Indicators and Targets

REDACTED

Partners and Implementing Mechanisms

Partner List

Mech ID	Partner Name	Organization Type	Agency	Funding Source	Planned Funding
9187	Hindustan Latex Family Planning Promotion Trust	NGO	U.S. Agency for International Development	GHCS (USAID)	650,000
9189	Johns Hopkins University Bloomberg School of Public Health	University	U.S. Agency for International Development	GHCS (USAID)	798,105
9190	LEPRA Society	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention		
9191	MYRADA	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention		
9193	Share Mediciti (Networking)	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention		
9194	Share Mediciti (Umbrella)	NGO	U.S. Department of Health and		

			Human Services/Centers for Disease Control and Prevention		
9195	Tamil Nadu AIDS Control Society	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GAP, GHCS (State)	600,000
9196	University of Manitoba	University	U.S. Agency for International Development	GHCS (USAID)	3,292,112
9249	Family Health International	NGO	U.S. Agency for International Development	GHCS (State), GHCS (USAID)	1,377,954
9254	Children in Need Institute	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention		
9349	University of Washington	University	U.S. Department of Health and Human Services/Health Resources and Services Administration	GHCS (State)	1,100,000
9350	Project Concern International	NGO	U.S. Department of Health and Human Services/Centers		

			for Disease Control and Prevention		
9863	Population Services International	NGO	U.S. Agency for International Development	GHCS (State), GHCS (USAID)	3,900,000
10085	Share Mediciti (Umbrella)	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	700,000
10964	Voluntary Health Services	NGO	U.S. Agency for International Development	GHCS (USAID)	3,910,000
10975	Avert Society	NGO	U.S. Agency for International Development	GHCS (USAID)	2,200,000
10982	US Department of Defense	Own Agency	U.S. Department of Defense	GHCS (State)	582,195
10983	US Department of Labor	Own Agency	U.S. Department of Labor	GHCS (State)	294,667
12401	Family Health International	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	600,000
12402	Project Concern International	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and	GHCS (State)	700,000

			Prevention		
12403	TBD	TBD	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Redacted	Redacted
12404	Abt Associates	Private Contractor	U.S. Agency for International Development	GHCS (USAID)	200,000
12405	AIDSTAR I, Task Order#1	NGO	U.S. Agency for International Development	GHCS (USAID)	2,100,000
12406	GH Tech	Private Contractor	U.S. Agency for International Development	GHCS (USAID)	989,272
12407	Macro International	Private Contractor	U.S. Agency for International Development	GHCS (USAID)	500,000
12408	Boston University	University	U.S. Agency for International Development	GHCS (USAID)	450,000
12409	Management Sciences for Health	NGO	U.S. Agency for International Development	GHCS (USAID)	250,000

Implementing Mechanism(s)

Implementing Mechanism Details

Mechanism ID: 9187	**Mechanism Name: HLFPPT**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Hindustan Latex Family Planning Promotion Trust	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 650,000	
Funding Source	**Funding Amount**
GHCS (USAID)	650,000

Sub Partner Name(s)

TBD		

Overview Narrative

Background:

HLFPPT is implementing a condom social marketing (CSM) program among high-risk populations in 33 high prevalence districts in Maharashtra State. HIV prevalence in the state is 0.67% among pregnant women attending antenatal clinics (ANC), a decline from 1.5% in 2003. There are a number of factors that contribute to Maharashtra's vulnerability to the HIV epidemic. It is bordered by other states that have well-established and growing HIV epidemics (Karnataka and Andhra Pradesh). There is extensive migration to and from these states, and there are major transportation routes connecting Maharashtra to them. Maharashtra is a major destination hub for migrants from various states of India. Additionally, Mumbai and several other districts have well recognized places where sex workers operate. The HIV prevalence reported among the most-at-risk-populations (MARPs) is high: 12.8% among female sex workers (FSWs), 16% among men who have sex with men (MSM), 20% among injecting drug users (IDUs) and 10% among STD clinic attendees.

The goal of the condom social marketing program is to ensure availability and accessibility of high quality condoms to most-at-risk-populations (MARPs) such as FSW, MSM, IDU, migrants and people engaged in

high-risk behavior. The specific aims of the project are to provide technical assistance (TA) to Maharashtra State AIDS Control Society (MSACS), Mumbai District AIDS Control Society (MDACS), Goa State AIDS Control Society (Goa SACS) and the Avert project in designing, implementing and evaluating condom programming targeted at MARPs and vulnerable populations; to demonstrate CSM models for FSW, MSM, migrants and PLHIV; and provide technical support to the SACS in scaling-up the female condom promotion program.

HLFPPT works closely with the Avert project, MSACS, MDACS, Johns Hopkins University (JHU) and other partners in the implementation of the CSM program. It also collaborates with the Bill and Melinda Gates Foundation (BMGF) and other condom social marketing partners in expanding the program among MARPs while avoiding duplication of efforts.

HLFFPT has supported the state AIDS control society (SACS) in strengthening the logistics and the supply chain systems for male and female condoms including building their capacity in condom social programming. Specifically, HLFPPT is providing TA to the SACS in establishing the various systems including planning, procurement and monitoring of the female condom promotion program. In addition, HLFPPT is also supporting SACS in developing systems for scaling-up the condom vending machines program in high-risk locations of the state.

As part of the female condom promotion program, HLFPPT is training outreach teams including peer educators to promote female condoms among sex workers as an effective device to give them greater control over their own protection, without having to rely on their partners to use a condom.

HLFPPT has established a robust monitoring system to track the outputs and outcomes of the various CSM programs including the technical assistance activities for SACS. The CSM indicators have been integrated into the SACS and Avert management information system (MIS) through which the progress of the activities is monitored. In addition, HLFPPT in consultations with the SACS and Avert project has developed a monitoring checklist for assessing the effectiveness of the field level CSM activities designed for MARPs. HLFPPT has developed a retail sales tracking system that will track condom sales of at retail outlets (13,500) established in high-risk locations. As regards to female condom promotion program, sales and condom usage are tracked routinely by SACS and Avert project.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Increasing gender equity in HIV/AIDS activities and services

Mobile Population

Budget Code Information

Mechanism ID:	**9187**		
Mechanism Name:	**HLFPPT**		
Prime Partner Name:	**Hindustan Latex Family Planning Promotion Trust**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	HVSI	312,000	

Narrative:

SUMMARY

The condom social marketing program (CSM) implemented by HLFPPT will come to an end in June 2011. Hence, in FY 2010, HLFPPT will focus on conducting evaluations of the various condom social marketing programs and document best practices and lessons learned. HLFPPT will disseminate the findings of the evaluations at the state and the national level.

ACTIVITY AND EXPECTED RESULTS

ACTIVITY 1: Evaluation of CSM Program for MARPs

HLFPPT has piloted the integration of CSM activities among FSW, MSM and migrant populations. HLFPPT will hire an external agency to evaluate the effectiveness of the CSM programs among MARPs. The key evaluation questions are:

1. How effective were the integration of the CSM strategies in prevention program for brothel based and non-brothel based FSW populations in improving access to condoms?
2. How effective were the CSM strategies for MSM population?
3. How effective were the CSM strategies for the migrant population?
4. How effective were CSM strategies for the trucking population?
5. What were are the lessons learned and challenges in integrating CSM strategies with the prevention

programs for MARPs including migrants and truckers?

ACTIVITY 2: Evaluation of the Sahi Condom Outlet Program

In FY10, HLFPPT will hire consultants to evaluate the effectiveness of the Sahi Outlet program in promoting quality condoms. The evaluation question is what proportion of the Sahi outlets are stocking approved condom brands (social marketing and commercial). A post program assessment will be conducted in FY 2010 which would help in measuring outputs and outcomes, analyze strengths and weaknesses and make changes accordingly.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	22,000	

Narrative:

SUMMARY

HLFPPT will provide technical assistance to the MSACS, Goa SACS and District AIDS Prevention and Control Unit (DAPCUs) in developing and operationalizing the CSM plans. Technical assistance will be provided in strengthening various systems, including logistics and inventory management of free condoms and promotion of female condoms. HLFPPT will also provide technical support to NACO in developing national guidelines on various components of the CSM program.

The SACS also need to form strong, ongoing partnerships with social marketing organizations and commercial manufacturers to increase condom sales for HIV prevention. The present capacity of the SACS to scale up and manage CSM programs is not adequate. Hence, it is critical to provide technical support to SACS in strengthening systems to plan, implement and monitor condom social marketing programs.

ACTIVITIES AND EXPECTED RESULTS

ACTIVITY 1: Technical Assistance to MSACS and Goa SACS

In FY 2009 and continuing in FY 2010, HLFPPT will provide technical assistance to both the SACS in developing condom social marketing plans including operational guidelines and establishing systems to implement and monitor CSM programs. HLFPPT is providing technical assistance in developing demand projections for the supply of free condoms, monitoring condom wastage, logistics and inventory

management and retail sales tracking. Technical support will be provided to SACS in developing systems and processes for generic condom promotion, expanding condom retail outlets including training retailers, partnership with social marketing organizations, and assessing condom quality. HLFPPT will also provide ongoing technical support to the SACS in establishing the various systems for planning, implementation and monitoring of the female condom and of the other condom program.

ACTIVITY 2: Technical Assistance at the National Level

HLFPPT will provide technical assistance in developing operational guidelines at the national level on various components of the CSM program including the promotion of female condoms and special condoms for the MSM population. HLFPPT will also provide ongoing technical assistance on specific activities such as the generic condom promotion program, condom retailers' training, partnership with social marketing organizations and condom manufacturers, condom quality testing and monitoring condom sales.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	316,000	

Narrative:

SUMMARY

HLFPPT supports the Maharashtra State's efforts in scaling-up CSM. In addition, HLFPPT provides technical support to Goa State AIDS Control Society (GoaSACS) on CSM initiatives in the state. In Maharashtra State, HLFPPT is demonstrating models of integrating CSM activities into the prevention programs for MARPs. In addition, HLFPPT provides technical support to the National Female Condom Promotion Program implemented throughout the country. HLFPPT is also implementing an innovative program called the "Sahi Outlet" (Sahi meaning "reliable") to promote quality condoms. The key technical strategies are to: enhance access to quality condoms for MARPs through focused distribution initiatives in high-risk areas; increase demand for condoms among MARPs and promote safer sexual behavior among clients of Female Sex Workers (FSWs) such as truckers, migrants and at-risk youth; and to provide technical support to promote female condoms for FSWs in the state of Maharashtra. HLFPPT will form a technical resource group to guide the various innovations in the CSM program.

ACTIVITIES AND EXPECTED RESULTS

ACTIVITY 1: Integrating CSM in Prevention Programs for FSW Populations

It is estimated that there over 70,250 FSWs in the State of Maharashtra. The FSWs can be classified into two types at a broader level – brothel-based which comprises 60-70% of the FSW population, and non-brothel based, which is further sub-divided into street-based, lodge-based and home-based FSWs. The brothel-based and the non-brothel based FSWs are two different sub-cultures and the HIV/AIDS programming is designed to suit to their community structures. Maharashtra State has well defined brothels in certain locations such as Mumbai (5000-7000 FSWs), Nagpur (5000 FSWs), Pune (5000 FSWs), Sangli and Sholapur (2000 FSWs each). Districts such as Thane (7000-10,000), Yawatmal, Kolhapur, Nasik and Ahmednagar (ranging from 2000 to 3000) have large concentration of non-brothel-based FSWs. There are over 70 NGOs working among FSWs in the state.

In FY09, HLFPPT is piloting two models of CSM targeting brothel-based and non-brothel based FSWs. A situational assessment will be carried out to design the integration of CSM into the brothel and non-brothel based FSW prevention programs. In a brothel-based FSW program, the design will include networking between peer educators (supported by outreach workers), brothel madams, other stakeholders as appropriate, condom retail outlets and the HLFPPT sales team. In addition, HLFPPT will also pilot peer-led and madam-led condom retail outlets. In a non-brothel based FSW program, the CSM design will be tailored to the communities in and around the lodge-based, street-based and home-based FSW. In a non-brothel based prevention program, the CSM will be centered on peer educators, pimps and lodge workers. The NGO implementing the prevention programs among FSW will be responsible to manage the CSM program. HLFPPT will develop monitoring tools and indicators in collaboration with state partners and NGOs to monitor progress. The aim of the CSM program is to ensure that over 80% of the FSWs and the clients have access to high-quality condoms. In FY10, HLFFPT will continue the CSM program in collaboration with state partners and NGOs and will evaluate the effectiveness of the CSM strategies.

ACTIVITY 2: Integrating CSM in Prevention Programs for MSM Populations

In FY09, HLFPPT will design a CSM program for over 80,000 MSM populations in the state of Maharashtra. The MSM typologies include Kothis (receptive), Panthis (intertie) and Double-Decker (local terminology for MSMs who are both passive and active). In addition, there are bisexual populations putting both men and women at risk of HIV. The MSMs solicit sex at toilets, cinema halls and public-parks. Unlike the FSW, the MSM populations do not have defined community structures. HLFPPT will implement the peer-based CSM program as this is the most suitable for MSM population. The other approach that is suitable to the MSM community is establishing condom vending machines in NGO offices, toilets and at locations near parks and cinema halls suitable to the MSM community. The NGOs implementing the prevention programs among MSM population will be responsible to manage the CSM program. HLFPPT will develop monitoring tools and indicators to monitor progress. In FY10, HLFFPT will

continue to strengthen the CSM program and will evaluate the effectiveness of the CSM strategies.

Activity 3: Piloting a CSM program for Migrant Textile Workers

Bhiwandi in Thane district is the largest exporter of silk and cotton cloth in Maharashtra State. Bhiwandi has 400,000 looms, and over 700,000 single male migrants from Uttar Pradesh, Bihar, Andhra Pradesh, Kerala and Tamil Nadu are engaged in the textile industry. The migrants are vulnerable to HIV due to several factors: being far from home; a lack of social identity, poor work environment and adverse living conditions with little recreation. They live in poorly ventilated and unhygienic clusters with 7-10 workers sharing a single room of 10'x10'. During power cuts and on holidays they spend their time watching movies, marketing, going to bar and visiting a brothel named Hanuman Tekri which is closely located to the textile industry. The brothel has over 993 FSWs. In addition, Bhiwandi has over 882 non-brothel based FSWs and 250 MSM.

The Avert project is piloting a migrant intervention program among the textile workers in Bhiwandi. The key stakeholders in this population are loom owners, mess owners (canteens specifically started for migrant populations) and community leaders. JHU is assisting the Avert project in designing a behavior change communication program for the migrant textile workers. The Avert project has identified and trained over 300 peer educators from among the migrant community. HLFPPT will conduct a situational assessment and design a CSM program tailored to the migrant community structures in Bhiwandi. In FY10, HLFFPT will continue the CSM program and will evaluate the effectiveness of the CSM strategies.

Activity 4: Technical Support to Implement Condom Vending Machine (CVM) Program

One of the key strategies of the National Condom Social Marketing Strategy is the establishment of CVMs in high-risk locations to increase access to quality condoms for MARPs including clients of FSWs. In the states of Maharashtra and Goa, HLFPPT is assisting the SACS in installing and monitoring the effectiveness of the CVM program. In FY08, CVMs have been installed in over 3,250 high-risk sites in Mumbai and Thane districts of Maharashtra State. The CVMs are installed in partnership with a local business partner (lodge owners, chemists, bar owners and shops) to manage the CVM. However, it was observed that this model of partnering with local business partners did not work as the CVMs were not routinely refilled. HLFPPT handed the responsibility of managing the CVM to the condom sales team who regularly ensure that the CVMs are refilled. The CVMs are installed at brothel sites, markets, hospitals, tourist locations and resorts. The sales through the CVMs are tracked. In FY10, HLFPPT will continue providing technical support to manage the CVM program and effectiveness of the program will be evaluated.

Activity 5: Training of Condom Retailers

HLFPPT has trained over 13,500 condom retailers from 22 high prevalence districts using the standard training curriculum and module. In FY10, training of over 6,500 condom retailers from the remaining 11 high prevalence districts (Maharashtra has 33 high prevalence districts) will be conducted. In addition, training for condom retailers from the two districts of Goa State will be conducted. An evaluation of the condom retailers training will be conducted in FY10.

ACTIVITY 6: SAHI Branding

HLFPPT is focused on reducing the availability of poor quality of condoms and will invest in developing non-traditional outlets (NTOs) which will only stock and sell quality condoms conforming to standards required for disease (STI) prevention. Creation of 3R Outlets (Red Ribbon Retail Outlets) within the universe of NTOs mapped in high-risk areas and branded as "Sahi" outlets increase awareness and accessibility of quality condoms at all times. HLFPPT plans to convert most of the NTOs, which were covered in the retailer training program in FY 2009 into SAHI outlets. The outlet would be branded with POP and other merchandise especially keeping in mind the sensitivity of the issue. The outlets will be provided programmatic support as it is important to retain the interest of the NTOs which can obtain higher margin by selling poor quality condoms. The NACO-funded CSM project will be leveraged to maintain the supply chain for the availability of quality condoms. In FY 2009, as a result of sustained efforts by HLFPPT, 2,278 non traditional outlets are stocking and selling quality condoms.

The campaign is further strengthened with messages on quality condoms and their availability for every sexual encounter among the MARPs. By FY 2010, the program aims to reduce the sale of poor quality condoms to less than 10% in the market in partnership with NACO and SACS, Consumer Forum, Excise department, Food and Drug Administration (FDA) and other concerned departments.

ACTIVITY 7: Technical Support to Implement the National Female Condom Promotion Program among FSW Population

As part of the national condom strategy, a female condom promotion program is being implemented among FSWs in selected states of the country. NACO is subsidizing the female condoms (FC). In FY 2007, a pilot assessment was conducted among seven NGOs working with FSW in Maharashtra State. The pilot assessment focused on positioning female condoms as a premium product which empowers the FSWs to have protection at all times. FCs was marketed at a highly subsidized price of Rs.5 per piece. This led to the use of FCs by the FSW with their temporary husbands with whom the condom use was quite low. The perceived pleasure enhancing factor and the premium perception of FC enabled the

FSW to negotiate female condom use with their clients. NACO introduced the polynitrile condom FC 2 which is priced at INR 2.00 for NGOs and INR 3.50 for the end user (FSW). In FY 2008, the FC program was scaled up to 65 NGOs supported by SACS, the Avert project and BMGF reaching over 50,000 FSWs in Maharashtra State. In FY 2009 and continuing in FY 2010, HLFPPT will strengthen the FC program to reach 80-90 % of the FSWs. To date, 83,000 FCs have been socially marketed to NGOs.

ACTIVITY 8 – Piloting CSM in Prevention with Positives Program

In FY 2009 and continuing in FY 2010, HLFPPT in partnership with Network of Maharashtra Positive People will integrate condom promotion with the positive prevention program in five Avert priority districts of Maharashtra State. The program will promote consistent condom use among sero-discordant couples and unmarried positive people. HLFPPT will also initiate condom promotion activities at counseling and testing centers, ART centers and in care and support programs.

ACTIVITY 9: Safe Zone Project

Maharashtra State has eight national highways with a total of 2564 km. More than 50,000 truckers pass along these highways every day. A workshop conducted in June 2008 with the trucking community (truck association members, Dhaba owners (restaurants at truck points) and members of the Transport Corporation of India) revealed that truckers have very limited access to condoms on highways where they spend most of their time, except at few NGO intervention sites. Once the trucks come out of these intervention points, there is very limited access to condoms along the national highways.

A pilot CSM project covering a km stretch of national highway-four, passing through five Avert priority districts in Maharashtra State will be implemented in FY 2009 and continued in FY 2010. The project will enhance availability, accessibility, and visibility of condoms to truckers along the entire route. A mapping will be conducted to identify the various service providers such as dhabas, small shops telephone booths, tyre repair shops and petrol pumps to develop them into non-traditional outlets for condom sales.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9189	**Mechanism Name: Center for Communication Programs at the Johns Hopkins University Bloomberg School of Public Health (JHU CCP)**

	(Health Communications Partnership Project)
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Johns Hopkins University Bloomberg School of Public Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 798,105	
Funding Source	**Funding Amount**
GHCS (USAID)	798,105

Sub Partner Name(s)

TBD		

Overview Narrative

With the growing complexity of the HIV epidemic, the National AIDS Control Program (NACP III) focus has shifted from raising awareness to behavior change, from a national response, to a decentralized response and an increasing engagement of NGOs and networks of people living with HIV/AIDS (PLHIV). The major emphasis of NACP III is on prevention, since more than 99% of the people in India are uninfected. The focus is on saturating high-risk groups such as commercial sex workers (CSWs), men who have sex with men (MSM) and injecting drug users (IDUs), vulnerable groups, namely migrants and truckers, with prevention messages. NACP–III also seeks to implement the principle of a continuum of care that includes management of opportunistic infections and antiretroviral therapy (ART). The Government of India (GoI) has dedicated substantial resources to accomplish its goal of halting and reversing the epidemic.

The Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs (JHUCCP) with its global experience in the area of communication has provided technical assistance (TA) to GoI with USG funding. In India, the first phase of JHU CCP communication assistance was a field support activity (Oct 2004- July 2007) under the Global Health Communication Partnership (HCP) program. It was marked by development of campaigns focused on youth, workplace, care and support.

In phase two (July 2007-June 2011), JHUCCP through an Associate Award (AA) under HCP provided TA to the National AIDS Control Organization (NACO), Maharashtra and Goa State AIDS Control Societies (SACS) as well as other SACS in the design, development and operationalization of strategic

communication programs for different thematic areas. The target audiences for prevention include most-at-risk-populations (MARPs), vulnerable populations and young women and men in high prevalence districts. Programs also included messages for the general public in an attempt to reduce stigma and discrimination. JHUCCP will continue to work closely with the government to create proto-type creatives that will be mass produced and distributed by GoI. The mass media and other audio visual materials will also be rolled out with GoI funds. An amount of $4.76 million has been leveraged from GoI for all the campaigns developed for NACO in FY 07-08.

The communication program will build on lessons learned, replicate and consolidate current communication activities and build capacity for successful and sustained implementation of communication activities at state and national levels. In keeping with the PEPFAR vision, JHUCCP's goal is to identify and build the capacity of local organizations to sustain strategic communication in the country.

JHUCCP has developed and scaled-up campaigns for Youth, Workplace Interventions, Care and Support for NACO at the national level. In FY08, JHUCCP developed a national campaign for generating demand for Integrated Counseling and Testing Centre (ICTC) services with focus on increasing awareness among pregnant women about the benefits of prevention of mother-to-child transmission (PMTCT) program. The launch of the campaign was preceded by a baseline study in all 35 districts of Maharashtra and findings shared with NACO, Maharashtra State AIDS Control Society (MSACS), Mumbai District AIDS Control Society (MDACS) – specifically established for Mumbai being a large city and an epicenter of HIV. JHUCCP also developed a national campaign to address stigma and discrimination faced by children infected and affected by HIV/AIDS. The innovative 'Dabbawalas' (Daba+walla – Dabba refers to lunch box and Walla to persons paid to carry the lunch boxes from home to workplaces) communication campaign reached 100,000 people at workplaces over a period from 2005-2007. A music video for young people was produced to promote protective behavior. JHUCCP also provided TA to NACO for developing materials for increasing adherence to ART.

JHUCCP is providing TA at state/national level for an integrated communications program in prevention, counseling and testing and care and treatment services for Most-at-Risk Populations (MARPs) and other vulnerable populations. JHUCCP developed a range of innovative materials addressing safe behavior for use by NGOs during interpersonal communication (IPC). JHUCCP will train NGO staff in the effective use of these materials and in IPC. Media advocacy workshops were conducted across the state for media professionals and news coverage tracked before and after workshops to assess the effects of the workshops. In collaboration with the Indian Express group an award for "Excellence in HIV/AIDS Reporting" was given for the print media in Marathi and English.

JHUCCP is providing TA in various aspects of behavior change communication (BCC) to NACO. Some of the examples of this TA include: capacity building of radio program producers to develop radio programs addressing vulnerable youth and rural women; development of a communication strategy for interstate migrants; evaluation of activities implemented under the District Communication Action Plan (DAP) in the district of Aurangabad; and scaling up of DAP in other districts of Maharashtra.

A workshop on Leadership in Strategic Health Communication was conducted by JHUCCP for SACS, NACO and other partner staff. Simulated software 'SCOPE' (Strategic Communication Planning and Evaluation), adopted for evidence-based planning was used at the workshop. Efforts are in place to institutionalize the workshop.

Capacity-building of NGO partners including refresher trainings in communications skills and use of various media and materials was also carried out. JHUCCP is a member of the IEC /Youth Technical Resource Group at NACO, and its core committee to evaluate and provide technical inputs on content of materials for MARPs.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Mobile Population

Budget Code Information

Mechanism ID:	**9189**		
Mechanism Name:	**Center for Communication Programs at the Johns Hopkins University Bloomberg School of Public Health (JHU CCP) (Health Communications Partnership Project)**		
Prime Partner Name:	**Johns Hopkins University Bloomberg School of Public Health**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**

Care	HKID	90,000	

Narrative:

Summary:

There are very few materials that focus on the information needs of HIV affected and infected children and provide children basic information on psychosocial issues, nutrition, possible side effects of ART and importance of adherence. These types of materials are needed to bring out the main issues that OVC face in their day-to-day lives and may be used by parents and care givers as discussion starters on the issue of HIV/AIDS.

ACTIVITIES AND EXPECTED RESULTS

ACTIVITY 1: Technical Support to Develop Communication Materials for OVC programs

In FY08 and FY09, two sets of story books on themes of HIV/AIDS are being developed for children affected and infected with HIV. These books are being developed for children of two age groups (6-11years) and (12-16 years). Each book will have a set of 5 stories along with illustrations and interactive activities for children at the end of each story.

In FY10, JHU CCP will step up efforts in providing need based technical support to the Avert project for their OVC projects. Depending on the requirements of the OVC projects technical support could be in the form of developing specific communication materials for OVC activities conducted by health care providers, parents, guardians and caregivers on the provision of basic health care and nutritional support for OVC at home and in institutional settings. Building on the communication materials that JHU CCP has already developed, additional materials may be developed to address stigma and discrimination against OVC at the community level and at schools.

In FY10, a monitoring and evaluation plan will be designed and implemented to understand the reach of the "Story Books." The research will include qualitative feedback from children and their caregivers as well as from NGO/CBO staff. Service statistics of NGOs/CBOs will also be tracked to measure the reach of the set of story books developed by JHU CCP. Qualitative measures will be used to understand the way these books are being used and their effect on children. Efforts will also be made to translate the stories in other languages and intensify the dissemination of the books to other states through the different SACS and NACO.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	HTXS	95,000	

Narrative:

Summary:

The advent of antiretroviral therapy (ART) has made possible better quality of life and dramatic decrease in mortality among HIV-infected people. But very high levels of adherence are required for ART to be effective. At least 95% adherence to medications is required for a sustained response. Unfortunately, non-adherence remains a formidable barrier in the management of HIV, resulting in development of resistance and drug failure. Although the Indian National ART Program was launched in April 2004, adherence remains a public health concern and there is limited information regarding levels of adherence.

There is need for adequate preparation of patients prior to initiating ART and incorporating adherence support measures for all patients receiving ART. Despite some attention to adherence in recent years, much more remains to be done to better understand and promote adherence to ART through effective communication materials. For addressing the issue of adherence, there is need for a comprehensive range of materials which includes information counseling, reminders, reinforcement and self monitoring.

ACTIVITIES AND EXPECTED RESULTS

Activity 1: Technical Support for developing materials on ART adherence

In FY09, NACO replicated and adapted a care and support kit developed by JHU CCP for PLHIV which contained materials on ART adherence. Further in FY09, NACO rolled out a poster on registration at ART centers and importance of ART adherence developed by JHU CCP. In FY10, JHUCCP will provide technical assistance to NACO to develop communication materials to improve adherence to ART regimens among adults. This could be in the form of job aids for counselors to counsel on ART or take-away materials for clients on the importance of adhering to the ART regimen.

The key monitoring and evaluation objective will be to understand the reach and effectiveness of various communication materials and reminder tools on ART adherence. Research will include feedback from both client (PLHIV) and service providers such as NGO/CBO staff and care givers, on ART adherence, and this will be captured with the help of qualitative research tools. Service statistics of PLHIV groups, NGOs/CBOs will be tracked to measure reach of the materials.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	HVCT	93,105	

Narrative:

Summary:
It is important that an individual who is HIV-infected is aware of his/her status as otherwise he/she could unknowingly transmit the virus to others. As of today, only 25–30% of the people who are HIV positive in the country are aware of their HIV status. According to NACO, the challenge faced today is to make all HIV-infected people aware of their status so that they adopt safe behaviors and a healthy lifestyle to prevent transmission of HIV to others, and also access life-enhancing care and treatment services. Hence, HIV counseling and testing services are a key entry point to prevention of HIV infection, treatment and care of people living with HIV/AIDS (PLHIV) and to control the spread of HIV/AIDS in the country. In FY 08, based on a request from NACO, JHU CCP started developing a national campaign targeted to increase awareness about the availability of a range of services at the Integrated Counseling and Testing Centers (ICTC) and generate demand for ICTC services. Based on the main sources of knowledge for HIV/AIDS, the campaign utilizes multiple and appropriate channels of communication and includes mass, outdoor and print media to generate demand for the ICTC services. NACO has identified that less than 10% of the MARPs are accessing the public sector ICTC services. The national counseling and testing (CT) plan has articulated a comprehensive strategy to increase of the coverage CT services for MARPs and has outlined the need to develop innovative demand generation campaigns addressing the needs of the MARPs.

ACTIVITIES AND EXPECTED RESULTS

Activity 1 Provide Technical Support for Implementation of the Ongoing ICTC Campaign to Create Demand for ICTC Services

JHU CCP has developed a campaign for NACO in FY08 for generating demand for ICTC services which has been implemented by NACO nationally and in Maharashtra by the MSACS, MDACS and Avert project for the last two years.

In FY09, JHU CCP integrated messages about counseling and testing in all the materials developed and disseminated to the MARPs. In FY09, JHU CCP also developed an interactive training toolkit with a video accompanied by a facilitator's guide for training of trainers (TOT) who will conduct training for counselors at ICTCs. This interactive training toolkit, with a stop and start video component demonstrating ideal counseling sessions, was developed per NACO's request and used during the ICTC counselors' trainings in the country. In FY10, JHU CCP will provide technical assistance to NACO in replicating the training toolkit in other languages and in conducting refresher trainings for the master trainers.

During FY10, JHU CCP will continue to provide technical assistance to NACO, MSACS, MDACS and the Avert project to create demand for ICTC services, specifically targeting MARPs and vulnerable populations. JHU CCP will assist in the development of materials for the ongoing ICTC campaign, will assist in the technical review of materials, media planning and support the implementation, monitoring, and evaluation of the campaign.

Additionally, in FY10, JHU CCP will disseminate the evaluation report of the end-line survey and develop/modify the ICTC demand generation campaign and communication materials to meet the needs in Maharashtra state, to increase the uptake of services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	100,000	

Narrative:

Summary:

The Center for Communication Programs/Johns Hopkins Bloomberg School of Public Health (JHU/CCP) will provide technical assistance (TA) to the Maharashtra State AIDS Control Society (MSACS), Mumbai District AIDS Control Society (MDACS), Goa State AIDS Control Society (GoaSACS), Uttar Pradesh State AIDS Control Society (UPSACS), Avert project, the National AIDS Control Organization (NACO) and other USG partners for developing formative research, and monitoring and impact evaluation as needed to cut across all stages of design and implementation of the communication program. JHU/CCP will provide expertise in evidence-based programming, ensuring the application of state-of-the-art individual behavior change and social change perspectives as well as robust methodological analyses.

ACTIVITES AND EXPECTED RESULTS

In continuation of FY08 and FY09 activities, in FY10, JHU CCP will provide TA at the national and state level to monitor and evaluate effectiveness of various communication programs.

ACTIVITY 1: Designing an Evaluation Methodology and Monitoring Tools to Assess the Effectiveness of Communication Activities

In FY10, JHU CCP will assist NACO, MSACS, Goa SACS, Uttar Pradesh SACS, and Avert project to evaluate the communication campaigns/activities. JHU CCP will assist the agencies in designing an evaluation methodology, including sampling and interview tools, to assess the effectiveness of the materials, messages and media-mix in terms of behavioral objectives and project-wide indicators. JHU

CCP will also provide TA for developing the evaluation protocol, selecting the agencies, implementing the evaluation and using evaluation data for program planning.

In FY10, JHU CCP will provide TA in evaluating the impact of the District Communication Action Plan roll out in the State of Maharashtra, the use of IPC materials with MARPs and the impact of the migrant communication strategy implementation on migrants and their families in the source and destination sites. In addition, TA will also be provided to NACO to assess the impact of the campaigns to increase the uptake of services among pregnant women in the focus States where NACO has rolled out the PMTCT campaign, the impact of the IPC skills building training on the quality of counseling among the ICTC counselors, the effect of the children's books on OVC and their caregivers, the usefulness of the ART adherence materials for PLHIV and the overall capacity built for strategic communication at SACS and the NGOs they support. Through the process of working with SACS and NACO to measure the impact of their programs, their capacity in monitoring and evaluation will also be strengthened.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	160,000	

Narrative:

Summary:
JHU/CCP implements a targeted HIV/AIDS communication program in Maharashtra State under the Avert project. In the first phase (ended in July 2007), JHU/CCP provided TA to the state in the design, implementation, monitoring and evaluation of behavior change communication (BCC) activities in HIV/AIDS across a range of issues including advocacy, work place interventions, NGO capacity building, youth, care and treatment and high-risk behavior interventions. Several of these activities and approaches have been adopted by NACO for national level use. In FY08 and continuing in FY09 JHU/CCP will provide technical support to MSACS, MDACS, GoaSACS, Uttar Pradesh SACS and Avert project in the design, development and operationalization of communication programs. The aim of the communication program in Phase two of the JHU/CCP project (July 2007-June 2011) is to support the TA needs of the National AIDS Control Program and also to support the state of Maharashtra in developing a unified communication response including uniform communication messaging, product development and implementation. As the second phase of the program comes to an end in FY10, constant and strategic efforts will be made to build the capacity of the partner organizations, both government as well as NGOs, in continuing to engage in strategic communication program planning and evaluation. In order to accomplish this sustained effort, capacity building of government partners, stakeholders and the NGOs becomes essential as well as identifying and training other local resources that can carry the agenda forward.

ACTIVITIES AND EXPECTED RESULTS

In continuation to FY08 and FY09, in FY10, JHUCCP will continue scaling up of following activities at national and state level:

ACTIVITY 1: Institutionalization of Follow-up Workshop on Leadership in Strategic Health Communication Workshop

In FY08 the Leadership in Strategic Health Communication workshop was organized for NACO, DAPCUs and Technical Support Units (TSUs) of Maharashtra, Karnataka, Goa, Uttar Pradesh, Tamil Nadu, Andhra Pradesh and other partners. This intensive training program was designed in a manner that would best serve the needs of the SACS, TSUs and other partners to effectively design and implement evidence-based communication strategies.

The framework of the Workshop was the P-Process, developed by JHU/CCP as a conceptual planning model. NACO's IEC Operational Guidelines follows the same P-Process framework developed by JHU CCP as the conceptual model for developing effective communication programs. The workshop first introduced participants to key concepts of strategy development (i.e., hierarchy of effects, the multi-stage approach to planning, and the concept of strategic leverage) and then delved into the five steps of the P-Process: Analysis, Design, Development, Implementation & Evaluation, and Review.

The workshop used SCOPE (Strategic Communication Planning and Evaluation), an interactive computer software simulation planning tool, that assists users in designing and implementing effective health communication projects. Developed by JHU CCP, SCOPE integrates communication theory and strategies with actual data from India and specific information from Maharashtra. The process trained participants to make decisions based on qualitative and quantitative data.

During FY09 another workshop will be conducted for the senior officials from NACO and SACS. It is envisaged that this training workshop will be institutionalized during the FY10 within a growing, learning organization in India so that the process of capacity building of health professionals in strategic communication is sustained.

ACTIVITY 2: Implementing and Monitoring District Communication Action Plans

Under the National AIDS Control Program Phase III, HIV programs will eventually be integrated into the National Rural Health Mission (NRHM) framework for optimization of resources and to ensure sustainability of interventions. At the district level, DAPCU will ensure implementation and monitoring of

the communication plan.

In FY 09, JHU CCP assisted the Avert project in developing and implementing a district-level communication plan for the district of Aurangabad in Maharashtra State. The HIV/AIDS communication activities were integrated with the existing district level plan of MSACS for implementation of prevention, care and treatment services along with the National Health Rural Health Mission (NRHM) machinery. Aurangabad DAPCU was responsible for monitoring the communication activities. JHU CCP in collaboration with SACS and Avert project will develop communication plans for the remaining 34 districts in Maharashtra and two districts in Goa.

In FY10, JHU CCP will continue to assist MSACS, MDACS, GoaSACS and Avert project in reviewing, developing and implementing the plans for the year, based on the communication needs identified. JHU CCP will also provide technical support for capacity building of the existing NRHM workforce other health service personnel such as link workers, NGO peer educators and outreach workers, to strengthen the implementation and for evaluating the communication plan.

Operational guidelines will be finalized in FY10 on how District Communication Action Plans can be designed and rolled out in a collaborative and synergistic way, how capacity can be built for sustaining the plans in the future, how the impact of such a synergistic plan can be assessed and how this can assist in influencing policy frameworks. In FY10, the evaluation data on impact of the district communication action plans in Maharashtra will be disseminated.

ACTIVITY 3: Refresher training for National level Master Trainers for Training of ICTC Counselors on Interpersonal Communication and Counseling (IPC/C) Skills.

The 12 day training that ICTC counselors across the country receive does not adequately cover interpersonal communication and counseling skills and neither does it include training on the effective use of materials. In FY08, an interactive interpersonal communication skills building module had been developed for training counselors to help them understand the basic principles that they needed to follow while communicating with their clients in order to make the client-provider interaction more effective. The module along with orienting them on the basic principles of interpersonal communication was meant to build their skills around other issues which directly or indirectly affected their interaction with clients. The training module consisted of participatory techniques for transacting the contents with the participants. The sessions were supported by a specially designed stop and start video to demonstrate both effective as well as ineffective styles of communicating with clients.
Along with developing the module, JHU CCP had also been involved in training Master trainers deputed by NACO to roll out the training in states across the country. During FY10, refresher trainings will be

carried out for the Master trainers to help address issues that they would have faced while carrying out the trainings and also refresh their learning.
The overall Monitoring and Evaluation objectives are to understand the knowledge and attitude of the workshop participants and communication skills including use of IPC tools. Pre and post workshop interviews will be conducted to examine changes in knowledge, skills and attitudes among the Counselors who attend the training workshops.

Visualization in Participatory Planning (VIPP) methodology will be used during the workshop to understand the awareness of participants and the obstacles in dealing with clients. Communication skills including effective use of IPC tools by the counselors will be tracked using the Observational and Client feedback approach. Observation using a checklist will be conducted among a sample of counselors who participated in the training to understand how efficiently and effectively they are using their skills in practice. Client feedback will also be collected using exit interviews to understand the quality of counseling. Also an attempt will be made to understand how clients attribute their behavioral changes to the interaction with Counselors.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	165,000	

Narrative:

The key communication approach to working with most-at-risk populations (MARPs) is through interpersonal communication and counseling (IPC/C). It thus becomes important that these IPC sessions are effective and are adequately supported by messages and materials that are acceptable, appropriate, relevant, understandable, attention-getting, memorable, attractive, and credible to and have an impact on the intended audience. There was also a need expressed by NACO, the Avert project, Mumbai District AIDS Control Society (MDACS) and Maharashtra State AIDS Control Society (MSACS) for specific communication materials for the NGOs working with different target groups among the MARPs.

People move from one place to another-temporarily, seasonally or permanently. Migration and mobility increases vulnerability to HIV, both for those who are mobile and for their partners back home. Back at their place of origin or home, female spouses/partners of migrants are vulnerable to HIV if their husbands/male partners are infected with HIV. Some wives/female partners also have their own sexual networks in the absence of their husbands/male partners. Female migrants are also at risk of HIV through transactional sex. For women, lack of knowledge, poor negotiation skills and decision-making power, traditional gender roles in Indian society together with poor health seeking behavior, poor adoption of safer sexual practices with both their husbands and other sexual partners facilitates the spread of HIV. An ideal response with migrants should address HIV prevention, care and support before

they leave (source), as they travel (transit), in communities and areas where they stay and work (destination), and after they return home (source /place of origin).

ACTIVITIES AND EXPECTED RESULTS

ACTIVITY 1: Designing Communication Campaigns for Most-at-Risk-Populations (MARPs)

In FY08 & FY09 JHU CCP conducted a series of workshops with NGOs working with MARPs and developed a set of innovative materials for outreach workers (ORWs) and peer educators (PEs) to work with their target populations of female sex workers (FSWs), men who have sex with men (MSM), injecting drug users (IDUs) and transgendered. A compilation of street play scripts with accompanying card puppets and other games and activities were also developed and disseminated. In FY09, monitoring tools are being developed with the help of the Avert project, MSACS and MDACS. These tools will monitor distribution/flow and utilization of various communication materials.

In FY09, JHU CCP will finalize a second set of communication materials for MARPs. JHU CCP will disseminate the MARPs communication materials at the national level and provide support to NACO, SACS and District AIDS Prevention Control Unit (DAPCU) to replicate the material in local languages. NACO, MSACS, MDACS, GoaSACS and Avert project will replicate MARPs communication materials as needed by their NGOs /CBOs.

JHU CCP will provide TA to the training of trainers (TOT) that will be conducted for MSACS, MDACS and the Avert project on effective interpersonal communication, effective use of communication materials and use of the monitoring tool developed by JHU CCP to track the use of the materials. These trainers will further conduct a series of trainings for NGOs/CBOs working with the SACS and DAPCUs to train their ORWs and PEs.

In FY10, JHU CCP will gather feedback about the utility and effectiveness of the materials developed and used by outreach workers (ORWs) and peer educators (PEs) of NGOs supported by MSACS, MDACS, Goa SACS and Avert project. In FY10, an impact evaluation will be conducted to asses use and effectiveness of these materials by the ORWs and PEs through a mix of qualitative and quantitative research techniques. The impact of the NGO outreach work on the target audience, supported by these inter-personal communication materials, will also be evaluated.

The process regarding the MARPs communication material development and the curriculum of the training workshops will be documented in detail in order to institutionalize the process at SACS and DAPCUs.

ACTIVITY 2: Communication Strategy and Campaign Development for Migrant Population:

In spite of the fact that migration is a continuum with different stages – source, transit and destination point – the bulk of HIV related migration programming has been directed towards migrants in their urban destinations. As a result, where migrants came from, how they travelled and the situation of their families left behind were largely left unaddressed by stand-alone destination based interventions. Current interventions do not adequately address the migrants' emotional, social and other service-related needs before departure, during travel and in the destination districts/states. Therefore, there was a need and rationale for establishing effective linkages between source and destination programs.

NACO, in consultation with partners at the national level has been working on a more comprehensive migrant intervention strategy. In FY 08, JHU CCP, in partnership with NACO, CARE India, the Avert project, MDACS and Uttar Pradesh SACS developed a 'source-transit-destination' migrant intervention plan with a communication strategy. JHU CCP will support the Avert project, MDACS and MSACS in the development of a Needs Assessment tool and communication strategy for migrant destination interventions. A baseline will be conducted at source in Uttar Pradesh and at destination in Mumbai/Thane which has the largest concentration of single migrants.

In FY09, as part of this communication strategy, a short film and other BCC materials and activities will be developed for migrants by JHU CCP. The materials will be rolled out by MSACS, MDACS and the Avert project in Maharashtra and by NACO through SACS in other States.

Further, in FY09, JHU CCP will provide technical assistance in the roll out of the pilot project linking source sites in Uttar Pradesh and destination projects in Maharashtra. JHU CCP will also conduct TOTs for NGOs involved in these interventions for effective IPC and effective use of communication materials and activities.

In FY10, an impact evaluation will be conducted at source, transit point and destination to understand the use and effectiveness of materials developed for migrant interventions in Maharashtra and Uttar Pradesh. This impact evaluation will also include case studies and qualitative research at source, destination and at transit points, depending on the kind of intervention.

In FY10, in consultation with NACO, JHU CCP will provide technical assistance to NACO for the scale up of these interventions to other states, linking the high prevalence in-migrant districts/sites to out-migrant source districts/sites.

ACTIVITY 3: Developing a Feature Film on HIV/AIDS

The influence that mainstream Hindi cinema has on the attitudes, lifestyles and larger social norms and values in India are well known. Mainstream Hindi films, popularly known as 'Bollywood Films' reach out to all sections of society and along with entertaining the public they mould their thinking in a subtle but effective manner in favor of what is depicted through them. They also often reflect the social realities of the times. There have been several 'cult films' that have sparked debate and also formed public opinion around important social issues such as child marriage, patriotism, religious tolerance, etc.

The biggest challenge towards effective implementation of prevention, care and support programs in the context of HIV/AIDS is the stigma associated with it. The stigma often stems from fear, ignorance, misconceptions and sometimes a culture of intolerance. Mainstream Hindi cinema with its all encompassing reach and power to influence public thinking provides a great opportunity to reach out to every nook and corner of the country in order to address stigma and discrimination and also bolster prevention efforts and public opinion.

JHU CCP would work with like-minded film makers and production companies to create a feature film addressing the various social dimensions associated with HIV/AIDS. The film would aim to create awareness, dispel commonly held myths and misconceptions, address issues around stigma and discrimination and most importantly make people realize that HIV/AIDS is something that they cannot turn a blind eye towards and that it is closer to their lives than they ever thought before. In the making of the film, JHU CCP will provide TA while the film company will fund the production costs.

The film that would be commercially released all over the country, would aspire to mobilize the country into a movement against HIV/AIDS and also create a supportive and enabling environment for PLHIV by destigmatizing them in particular and the epidemic in general.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	95,000	

Narrative:

Summary:
Peri-natal transmission accounts for 2.72% of HIV transmission in India. The Prevention of Mother To Child Transmission (PMTCT) program aims to prevent the perinatal transmission of HIV from an HIV-infected pregnant mother to her newborn baby. PMTCT is an important prevention strategy of the third phase of the National AIDS Control Program targeted at vulnerable populations in the high-prevalence districts. Given NACO's national mandate to increase the utilization of PMTCT services, an ongoing

national level demand generation campaign on Integrated Counseling and Testing Centers (ICTC) has a special focus on pregnant women, with the aim of increasing awareness about the availability of PMTCT services and the utilization of PMTCT services. As part of this campaign, specific materials for both mass media (TV and radio spots) as well as outdoor media (posters, bus panels, hoardings, bus shelters) have been developed addressing the issue of PMTCT.

ACTIVITIES AND EXPECTED RESULTS

ACTIVITY 1: Provide Technical Support for Implementation of Campaign to Create Demand for PMTCT Services

In FY08 and FY09, as part of the national PMTCT campaign JHU CCP developed a new TV spot and outdoor media promoting PMTCT services. This was implemented by NACO nationally. Flashcards on PMTCT were developed as job aids for auxiliary nurse midwives (ANMs) to help them to refer pregnant women to PMTCT and ART centers. In FY09, the content and messages of the flashcards will be finalized and illustrations and design of the flashcards will be completed.

During FY10, JHU CCP will continue to provide technical assistance (TA) to NACO, MSACS, MDACS and the Avert project to create demand for PMTCT services. NACO's FY10 needs in the area of PMTCT will be better understood in FY09 and JHU CCP will be responsive to those needs.

JHU CCP will assist in the development of materials, technical review of materials, media planning and support the implementation, monitoring, and evaluation of the ongoing PMTCT campaign. Special emphasis will also be given to the needs of female sex workers and the wives of migrants and truckers while designing the PMTCT campaign.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9190	**Mechanism Name: LEPRA SOCIETY**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: LEPRA Society	
Agreement Start Date: Redacted	Agreement End Date: Redacted

TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

(No data provided.)

Overview Narrative

LEPRA Society Health in Action is a health and development organization working to restore health, hope and dignity to people affected by leprosy, TB, Malaria, HIV and AIDS, blindness and other health conditions exacerbated by stigma and discrimination. LEPRA works in 4 states covering a population of 12 million. LEPRA started Jyoti Project, (implementing mechanism name) supported by USG in Andra Pradesh (AP) in 2005, with a goal to establish a community-led approach for prevention of HIV and providing care and support to people living with HIV/AIDS (PLHIV). The geographic coverage of Jyoti Project is 23 districts of AP and one district in Orissa. The following are the major activities of the project in the year 2009-10.

Key ongoing Activities:

• Providing technical assistance (TA) in mainstreaming HIV prevention in AP: This intervention empowers women by increasing knowledge and awareness, teaching negotiation skills to counter their vulnerability to STIs and HIV and trains them as peer educators and thereby increasing gender equity in HIV/AIDS programs. LEPRA and APSACS, provide TA to mainstream the HIV prevention activities into the Department of Rural Development's Indira Kranthi Padham (IKP) program to spread interventions to all female self help groups (SHGs_ in 23 districts throughout AP.

• Positive Prevention Tool Kit (PPTK) training program: USG and India CLEN developed a tool kit to address the counseling needs of PLHIV beyond pre and post test counseling,. LEPRA with the support of Andhra Pradesh State AIDS Control Society (APSACS) and USG initiated PPTK by training the master trainers, peer counselors of positive network and counselors of integrated counseling and testing centers (ICTCs) using PPTK. In FY09 the project provided supportive supervision, conducted refresher trainings and facilitated advocacy and dissemination meetings for the scale up of the intervention.

• Primary Health Centre Enhancement Project (PHCEP): LEPRA, through sub grantee Catholic Health Association of India (CHAI) and APSACS will continue to support nurse practitioners (NP) who provide comprehensive HIV/AIDS services in 10 districts and 266 ICTCs catering to 13 million. The services include counseling & testing (CT) for HIV, PMTCT, and community outreach in the villages. The project concentrates on improving the quality of services provided through refresher trainings, monitoring, and

supportive supervision in the FY09. The NP at the PHC-ICTC is a unique model and first of its kind in India. In FY09 the project with APSACS and other stakeholders will be transitioning to the National Rural Health Mission, which would also strengthen the existing health care systems in providing comprehensive HIV/AIDS services in the rural and remote areas in AP.

• Mobile CT services in east Godavari district, AP: East Godavari is one of the high HIV prevalent districts of AP. There are fixed ICTCs located in mostly limited to the urban and peri urban areas. This gap is bridged by MCT intervention. LEPRA will continue to provide TA to APSACS in functioning of MCTs, develop and operationalize standard operating procedures, document implementation and disseminate lessons learned and finally hand over the MCT to APSACS as this is the final year of the project.

• TA to National AIDS Control Organization (NACO) for quality assurance testing: LEPRA, through its sub-grantee India CLEN, will continue to provide TA to NACO to set up national and state level quality assurance services (EQAS) laboratories.

• Indian nurse specialist in HIV and AIDS and ART (INSHAA): LEPRA through its sub grantee CHAI in collaboration with USG, NACO, APSACS, Indian Nursing Council and I-TECH would be rolling out INSHAA a four week specialized training program for nurses working in ART and CCCs. The pilot will include participants from AP, Tamil Nadu, Karnataka, Maharashtra and Gujarat after which the curriculum would be finalized and more than 100 nurses will be trained from AP and other states in India.

Project Achievements and Innovations:

• Mainstreaming HIV prevention with Department of Rural development in AP: LEPRA organized one state level training of trainers (TOT), three regional level TOTs and trained the 310 master trainers of IKP-SERP. The district level TOTs in turn trained 374 health activists. LEPRA organized 286 IKP staff on monitoring the HIV prevention mainstreaming activity. The trainings conducted by health activists at village levels have been monitored by LEPRA project staff.

• Mobile CT services in east Godavari district, AP: Lepra provides TA to the district Collectorate of Hyderabad and APSACS in rolling out government MVCT services throughout AP. Lepra was also approached by APSACS to provide standard operating procedures for running MVCTs in AP.

• Positive Prevention Tool Kit training (PPTK): The complex physical, psychological and social vulnerabilities associated with being a person who is HIV positive necessitate the integration of follow-up counseling and positive prevention strategies into the existing counseling infrastructure. USG developed a positive prevention follow-up counseling toolkit was for the first time successfully introduced in AP. The PPTK has been translated into local (Telugu) language and state level TOT was conducted and identified master trainers from various NGOs. The peer counselors of the positives network have been trained on PPTK in four batches and 95 peer counselors were trained so far working in various HIV related counseling centers.

• Primary Health Centre Enhancement Project (PHCEP): For the first time in India through the PHCEP project comprehensive HIV/AIDS services were provided in the rural and remote areas. This project is

one of the model projects for task shifting where traditionally nurses provide clinical and community health services were trained in counseling and testing and in providing comprehensive services in the primary health centers. With these innovations and successful results National AIDS Control Organization (NACO) is planning to scale up in other states in India.

• Indian Nurse Specialist in HIV/AIDS and ART training program: This specialized training program for nurses working in ART and community care centers (CCCs) is first of its kind in India where USG and its partners are working with NACO. The project would be scaled up nationally after the pilot intervention.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9191	**Mechanism Name: MYRADA**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: MYRADA	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

(No data provided.)

Overview Narrative

MYRADA, a 40 year old field-based nongovernmental organization (NGO) works in the fields of: improving livelihoods of poor and vulnerable women; natural resource management, reproductive child health (RCH) and HIV/AIDS in the State of Karnataka. It is a recognized player in the field of HIV/AIDS. It provides technical assistance (TA) to various government and non-governmental projects. MYRADA's work is built on the underlying principles of sustainability and cost effectiveness. It empowers people to build local peoples' institutions and capacities and fosters effective linkages and networking.

MYRADA aims to address HIV and AIDS in a holistic fashion using its key principles of active participation, sustainability and cost effectiveness. The organization is extensively involved in implementing targeted interventions with urban high risk groups in five districts, link worker programs (HIV high risk prevention intervention program amongst rural high risk populations) in six districts of Karnataka, outreach counseling and testing (CT) model in four districts, setting up Red Ribbon Clubs (educational intervention among college youth to reduce HIV infection among youth by raising their risk perception and preparing youth as peer educators) in five districts, as well as providing technical support to various government and private agencies in the above areas.

All MYRADA's work in the area of HIV and AIDS is embedded in its key concept strategy called the ABC4DE strategy which is comprehensive prevention, care and support approach with A= Awareness: organized in general population; includes mass awareness; B= Behavioral change: through smaller groups; C4= Continence, Condom use, Community involvement, Continuity; D= Drugs, HIV care and support; E= Empowerment: livelihoods, linkages, CBO building.

Key Ongoing Activities:

• Link Worker Scheme: In order to reach the estimated 3,500 rural female sex workers (FSWs) and 10,000 people living with HIV (PLHIVs) in Chamrajnagar, Mandya, Kodagu and Bidar districts in Karnataka, MYRADA has established the following field models in over 400 villages:
• Core group interventions for high risk groups: condoms, sexually transmitted infection (STI) treatment and awareness through Community Resource Persons (CRPs) and local volunteers.
• Program for adult men in informal groups and women in self help groups (SHGs): basics of HIV and STIs for adults, addressing stigma and discrimination, and roles of these populations in HIV prevention, care, and stigma reduction.

• Youth interventions: using the Celebrating Life curriculum to address life skills and role of youth in mitigating stigma and discrimination.
• Strengthening the community based institutions: Gram Panchayat (GP) or the village council and Village Health and Sanitation Committees (VHSC).
• Gram Panchayat sensitization programs in over 500 GP.
• Capacity building of VHSCs in collaboration with National Rural Health Mission (NRHM)
• Community based care and support for PLHIVs and orphans and vulnerable children (OVC).
• CT through mobile teams at select remote primary health centers (PHCs).
• Policy and System strengthening
• Technical support to Karnataka State AIDS Prevention Society (KSAPS) in the areas of targeted interventions (TI), outreach for care and support, mainstreaming activities, and link worker program.

Project Achievements and Innovations:
• Developed a strategy on how to implement the link worker program in a sustainable and participatory manner and also prepared a document on the same.
• Provided TA to KSAPS to strengthen community outreach activities, evaluation of NGOs, HIV-TB programs, District AIDS Prevention and Control Units (DAPCU).
• Initiated link worker program in three new districts -Manyda, Bidar and Kodagu- in addition to Belgaum and Gulbarga. The latter are now run by Karnataka Health Promotion Trust (KHPT)- an USAID partner and Chamrajnagar.
• Demonstrated Red Ribbon Clubs and outreach CT services; and produced best practice documents.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Increasing women's legal rights and protection
TB

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9193	**Mechanism Name: APAIDSCON-Share Mediciti (Networking)**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Share Mediciti (Networking)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Andhra Pradesh (AP) is the fifth largest State in India in population and geographic area with a population of about 80 million across 23 districts, all of which are "A" category districts (as categorized by Government of India). As per the revised 2007 National estimates, AP has a prevalence of 0.96 percent among the adult population. The estimated adult population living with HIV/AIDS is about 450,000.

The National AIDS Control Organization (NACO) has identified priority thrust areas under National AIDS Control Program (NACP III) that include: MARPs saturation; rapid scale up of services; improved program management systems; decentralization of program implementation and management to the district level; strengthened data and strategic information management systems; laboratory support services and systems; a focus on access to quality services; mainstreaming of HIV services to other health and non-health departments; and integration with the existing general healthcare delivery services. In India, including Andhra Pradesh (AP), a significant level of health services (~60%) is sought in the private sector. Although the private sector provides that majority of health services, it remains untapped and unmonitored resource with regards to HIV/AIDS care and treatment. Such services continue to be

constrained by insufficient entry points and access, low treatment literacy among health workers and the general population, stigma and discrimination among the providers, non-uniformity of services, noncompliance to the national strategies, and a lax or lack of systematic data reporting system in the private sector. The quality of services provided by private medical facilities range from state-of-the-art to inadequate.

Realizing the need, strengths and potential of the private health sector and seeking to utilize the private sector's untapped resources, Science Health Allied Research Education (SHARE) India formed the AP AIDS Consortium (APAIDSCON) in 2005. SHARE India has a history of being involved in several health related projects since 1986, with an aim to "advance human health".

AP, the state with the highest estimated burden of HIV in India, has over 20 private medical colleges spread across 17 districts with 2,000 medical graduates each year. These institutions are between 3–10 years old and are at various stages of evolution. With the state-of-the-art technical and infrastructure, these colleges are located in rural or semi-urban settings and cater to underserved populations. They offer mostly no-cost or low-cost/subsidized services. Due to the availability of accessible and affordable services in these tertiary centers, they attract a sizeable population, including people living with HIV/AIDS (PLHIVs). Therefore, these institutions have tremendous potential and opportunity to play a leading role in the HIV epidemic.

APAIDSCON is a unique consortium of 16 private medical colleges and hospitals across 12 districts formed to address HIV and medical education as well as service issues. APAIDSCON built bonds with AP Nursing Homes Association, a 5,000 member body, to extend their linkages within private sector. The focus is on strengthening HIV-related activities and programs within its member organizations through developing and promoting a comprehensive multidisciplinary strategy to combat the HIV/AIDS epidemic. The development of this consortium has led to substantive system strengthening, including the successful completion of joint training programs, curriculum sharing, advocacy for government funded HIV testing and counseling centers in all 16 colleges and around 40 private hospitals, and a linkage system for subsidized CD4 testing.

APAIDSCON continues to involve the private sector in HIV and other public health programs through variety of partnership models with leveraged supports from public sector, private health sector as well private non-health sector. APAIDSCON plays a strategic role as an advocate, a technical assistance agency, a collaborator, and a contributor.

Current ongoing and future directions for the project include the provision of technical assistance to the local government counterparts and other partners in fostering partnerships. These include the private

sector for HIV clinical care, capacity building of the healthcare staff (medical, paramedical and allied staff), private sector policies, laboratory systems and innovative partnerships models. APAIDSCON is working to establish HIV testing quality assured services and design accreditation/certification models for APSACS to ensure provision of standard services across institutions both in lab settings as well as clinical care settings.

Broader Objectives of the Consortium are to:
• Open doors for PLHIVs and treat them without stigma and discrimination.
• Improve clinical competency of the network of physicians through in-service training programs.
• Foster and strengthen private and public collaborations to leverage resources within the communities of each member organization for effective program implementation and management of resources.
• Seamless introduction of national programs and policies into the private sector and seamless integration of private sector health data into the public sector monitoring and evaluation (M&E) system.

Activities undertaken:
• A unique model private sector consortium of 16 private medical college institutions formed.
• Structured two day and four day curriculum is being implemented for physicians for managing PLHIVs in the private sector without stigma and discrimination.
• Setting up of 16 counseling and testing centers and prevention of mother to child transmission (PMTCT) centers in the state with a system of reporting to AP State AIDS Control Society (SACS) and NACO through the national Computerized Management Information System (CMIS).
• Laboratory strengthening in terms of developing a quality assurance program for HIV rapid testing in both private and public sector in collaboration with APSACS, to enhance quality testing systems through structured standard operating protocols (SOP) and quality manual as per the national guidelines.
• Increased and improved provision of care and support services through innovative models: infectious disease (ID) clinics concept across seven institutions; Community Care Centers (CCCs) established in line with the NACO guidelines across three institutions; links built between Medical College ID Clinics and Community CCCs across six institutions; establish cells for post-exposure prophylaxis across all 16 institutions.
• Provision of HIV counseling and testing through a unique partnership model between the private sector, public sector and TA support from APAIDSCON.
• TA to APSACS in establishing and operationalizing Link ART centers in three districts of AP. TA, advocacy, as well as leadership in setting up private sector ART centers in partnership with the government.

To advocate and encourage active engagement of the private sector in implementing the national HIV program effectively, APAIDSCON will continue to work with the AP government and APSACS. The aim is

to expand HIV/AIDS interventions in the private sector and ensure that such services are delivered inline with the national HIV service guidelines.

The development of APAIDSCON is a noteworthy output and model for the country. One of the key outcomes of APAIDSCON is leveraging of funds of the private and public sector to implement quality programs inline with the national protocols.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Increasing gender equity in HIV/AIDS activities and services
TB

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9194	**Mechanism Name: Public Health Management Institute (PHMI)-Share Mediciti (Umbrella)**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Share Mediciti (Umbrella)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0

Funding Source	Funding Amount

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Implementing Mechanism Narrative

PHMI is a non-profit organization established in 2006, with a mission to improve quality of life through organizational capacity building and enhancing individual capacities of public health (PH) professionals. The goal of PHMI is to build human and organizational capacities improving systems for SI management, evidence based decision making, data based planning and program implementation by introducing scientific systems of needs identifications, assessments, trainings, building human capacities and addressing organizational challenges. The current focus of PHMI is on HIV/AIDS programs and related activities in Andhra Pradesh through PH trainings, providing consultants (India, AP and District), adopting scientific approaches for program planning, designing and implementation that emphasize the quality and standardization of healthcare delivery.

Objectives of PHMI:
1. To develop competency of PH workforce with special focus on HIV through:
i. The Public Health Field Leader Fellowship (PHFLF) program at State level, through the District AIDS and Prevention Control Unit's (DAPCU) capacity building initiatives at district level and the Data for Decision Making (DDM) training program for both the public and private. sector
ii. Short term trainings on Management, Communication, Advocacy, DDM, etc for district and state level managers
iii. Conducting continuing medical education and workshops encouraging the sharing of experiences and mainstreaming HIV interventions
iv. Creation of a virtual platform for information and knowledge-sharing among faculty, fellows and trainees
v. South to South collaboration: Provide assistance to state and national level PH workforce to gain knowledge from international field experience
2. Systems and policy strengthening by providing consultancy, manpower and TA to:
i. Local institutions such as Andhra Pradesh State AIDS Control Society (APSACS) and National Rural Health Mission (NRHM)
a. by placing technical experts as consultants for specific components under NACP III
b. by directly giving TA on various program components, activities or campaigns, data management, and analyses and dissemination in the context of program priorities

c. by assisting with quality documentation and reporting work
ii. NGOs (both USG and non-USG Partners) in AP and other areas in India

Key Ongoing Activities:
• System strengthening through TA by providing domain experts as consultants for strategic and evidence-based planning and implementation, as a support to APSACS and other developmental partners in AP, specifically:
• Consultants for (i) Surveillance, Monitoring and Evaluation (ii) Integrated Counseling and Testing Centre and (iii) DAPCU and NRHM Convergence programs
• Developmental partners and Local NGOs are trained for implementing HIV programmes as per NACP guidelines through direct human capacity development. Domain Experts from developmental partners were also called for these trainings
• Building human capacities of individuals and organizations for quality and standardized implementation of the NACP III program adapting scientific tools and instructional design-based approaches with National and State priorities. Activities under this include:
• Capacity building of DAPCU staff: On the basis of scientific training needs assessment by PHMI, APSACS developed a strategy for capacity building of DAPCU staff in five different phases
• A DDM Program based on international experience to provide both State and District level PH professionals with ongoing "in-service" technical training and mentoring assistance to use information and data for effective planning and program implementation
• Short term trainings for various PH personnel and NGO stakeholders for effective program planning, management and implementation e.g. Epi-Info, Excel, Data management, TI program management, Program Management (PM) and DDM
• Provide TA and trainings to support APSACS program managers in developing evidence-based decentralized action plans at the district level for implementation of HIV/AIDS services
• South to South collaboration to facilitate various stakeholders' sharing of programmatic experiences in larger national and international forums and also towards providing opportunities for capacity building of said stakeholders
• Develop a virtual and open source Learning Management System and web portal to share and disseminate various resources developed as well as a Public Health Human Resource Directory for AP to set up Human Resource Information systems within the State, as a model for larger replication.

Project Achievements and Innovations:
• Continue to assist 3 consultants at APSACS providing technical support in program planning and implementation in areas of Surveillance/M and E, ICTC and DAPCU/ NRHM convergence.
• Facilitated and provided TA to APSACS in decentralized evidence-based District Action Planning exercize with participation from approximately 1,400 HIV program staff representing 600 organizations,

who are developing an evidence based State annual action plan for 2009-10.
• Built capacity of all 23 districts' Additional District Medical and Health Officers (ADMHOs) in AP, and another 50 participants (Field Expert Group) for developing an evidence-based decentralized action plan.
• Assisted APSACS in recruiting 69 DAPCU staff (1 per district), including District Programme Managers, M and E assistant and Accounts assistant.
• Undertook orientation and induction training of all 69 DAPCU staff.
• As a part of APSACS capacity building strategy, trained 22 DPM on NACO- Targeted Interventions (TI), STI components and 23 M and E assistants on NACO- Basic Services Division (BSD), Blood Safety (BS), Computerised Management Information System (CMIS) and Monitoring and Evaluation
• Trained 89 participants from 64 TI NGOs on PM and 48 participants from various organisations on Epi-Info and Excel.
• Initiated and completed one year PHFLF program with a batch of 25 PH professionals; Internal and Mid-term Reviews have also been carried out.
• Provided TA for an integrated approach services mapping; training given to 65 outreach workers in one district of AP
• Organized a media sensitization workshop for journalists focused on interpretation of essential HIV/AIDS information in India and AP.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9195	**Mechanism Name: TNSACS**
Funding Agency: U.S. Department of Health and	Procurement Type: Cooperative Agreement

Human Services/Centers for Disease Control and Prevention	
Prime Partner Name: Tamil Nadu AIDS Control Society	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 600,000	
Funding Source	**Funding Amount**
GAP	400,000
GHCS (State)	200,000

Sub Partner Name(s)

National Institute of Epidemiology	TBD	

Overview Narrative

The Tamil Nadu State HIV/AIDS Control Society (TANSACS) is the implementing body for India's National AIDS Control Organization (NACO) in the southern state of Tamil Nadu, a high HIV-burden state. TNSACS, which is headed by a senior officer from the Indian Administrative Service (IAS), is the state-level authority for HIV-related policy formation, activity and partner coordination, program implementation, as well as monitoring, reporting, and evaluating on all activities related to the HIV epidemic in the state. In 1991, TNSACS was the first state HIV agency to be formed in the country and has continued to serve as a model for other such agencies around the country.

In 2002, the USG developed a formal relationship with TANSACS and in 2003 began providing fiscal and technical support. In FY10, the USG would renew its fiscal support for next five years. The USG continues to play a strategic role in the operations of TANSACS despite contributing only 3% of the TANSACS budget. The strong historical and technical relationship between TANSACS and the USG has allowed the USG to leverage the entire budget of TANSACS (approximately $20 million in FY08) effectively. This relationship is also strategic as jointly funded projects are likely to be replicated throughout the country as TANSACS is regarded as the leading state HIV agency in India. The technical support provided to TANSACS by the USG has been one of the successful models of donor support for the country. The extent, form, and specificity of our support was discussed with NACO, which resulted in the creation of the Technical Support Unit in Tamil Nadu that works directly with the USG advisors based at TANSACS.

There has been a consistent decline in overall trends of HIV prevalence in Tamil Nadu as well as in the country. However, some districts continue to have high prevalence in spite of all prevention efforts. It has been difficult to comprehend the factors associated with such disparate distribution of the disease in the state. The existing circumstances warrant strengthening the capacity for understanding the epidemiology of the epidemic including analysis and interpretation of data within the state AIDS control societies and state government staff in general. TANSACS and the USG have decided to develop a specialized training program in coordination with a U.S.-based university specializing in HIV epidemiology, with National Institute of Epidemiology (NIE) being considered as the most appropriate local organization to conduct the program. This training program is being developed for state (& central) government officials (from all over the country including TN) who would be deputed full time for the training period from their respective agencies/ departments. The agencies/ departments will commit to the deliverables from the staff that would be undergoing the training program. The following competencies will be expected from the trainees:

• Become part of the HIV surveillance teams at the state or national level (as required)
• Able to use statistical software (as defined by the program) to analyze relevant data from the field/ program
• Able to epidemiologically interpret the surveillance data and prepare reports
• Able to undertake both qualitative and quantitative research studies
• Able to write scientific papers and send them for publications to various peer reviewed national as well as international journals
• Able to conduct good quality HIV epidemiology and data management training sessions for program staff at the district and state level

The program, which will be one year duration, is expected to train 50 such epidemiologists over a period of five years, five happening within the first year.

With the continued financial, infrastructural and technical support provided by the USG, Government Hospital of Thoracic Medicine, Tambaram (GHTM) has been running successfully as the first Center of Excellence (COE) for HIV care in India. The USG through its partner ITECH has been providing technical support to NACO to strengthen the other COEs as well as strengthen and expand the national ART program through a very senior and experienced HIV physician. This will be further strengthened through additional two consultants hired through TANSACS. They will coordinate with NACO and ITECH and provide technical assistance to the other COEs (for training, research and lab strengthening) and evolve the implementation guidelines and do its follow up.

The USG will continue to support Government Hospital of Thoracic Medicine, Tambaram (GHTM) laboratory through Lab Manager, who will ensure the quality of lab investigations in GHTM. Further, as GHTM is State Reference Laboratory, he will provide technical assistance and monitoring to over 50

ICTCS under its supervision. The USG will also provide technical support to GHTM Lab for accreditation through National Accreditation Board for Laboratories (NABL). TheUSG will continue to support strengthening of external quality assurance system in the state and national level and it will evolve the systems to provide quality OI diagnostics at the level of state reference labs.

The USG will continue to provide technical, human, and financial support to the TB/HIV Information System (T/HIS) at the General Hospital of Thoracic Medicine, Tambaram (GHTM) and also identify means of mainstreaming it with NACO's MIS. T/HIS is a comprehensive electronic database that holds longitudinal patient records of over 370,000 (10 million patient interactions) patients at GHTM. The development and implementation of T/HIS has been supported by CDC and TNSACS for the past seven years through software development, hardware (i.e. computers, printers, local area network) and personnel.

In FY10 and FY11, the USG and TANSACS will continue their efforts to mainstream Red Ribbon Club (RRC) activities with the GOI Department of Higher Education and Department of Youth Affairs. RRC is an on-campus and voluntary educational intervention among college youth in Tamil Nadu that started in 2005. It is implemented with the twin objectives of reducing HIV infection among youth by raising their risk perception and preparing youth as peer educators and agents of change. Currently more than 1000 colleges across Tamil Nadu are being covered under this initiative.

The Tamil Nadu State AIDS Control Society (TANSACS) will continue to support an innovative program that reaches an estimated 5.2 million women through women's self-help groups (SHG), working in partnership with the Tamil Nadu Women's Development Corporation. The potential of SHG to address health issues is great, but previously has not been used as a channel for education and behavior change. The USG will continue to provide guidance for this training program, delivered by the government, which reaches women with comprehensive SHG messages, including the development of sexual negotiation and communication skills, and where to seek services for HIV counseling and testing and STI treatment.

The recently revised National AIDS Control Organization (NACO) estimates that 2.5 million people in India are living with HIV; meeting the demand for care and support for these PLHIV is a growing concern in India. To address this issue, TANSACS aims to train Health Care Providers on key aspects of Positive Prevention, specifically training on the Positive Prevention Counseling toolkit which was developed by the USG, TANSACS and partners. The complex physical, psychological and social vulnerabilities associated with being a PLHIV necessitate the integration of other key health care providers into the counseling infrastructure. This training will be complementary to other PLHIV-services-related trainings conducted by TANSACS including advanced counseling training, TB screening and referral, OI prophylaxis treatment and referral, and counseling on nutrition and psychosocial support).

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	10,000
Human Resources for Health	515,000

Key Issues

Increasing gender equity in HIV/AIDS activities and services

TB

Budget Code Information

Mechanism ID:	**9195**		
Mechanism Name:	**TNSACS**		
Prime Partner Name:	**Tamil Nadu AIDS Control Society**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	10,000	

Narrative:

SUMMARY

In India, an estimated 2.31 million people have HIV, all of whom require access to quality care. Counselors are often the first point of contact with the health care system. They play a critical role in linking people living with HIV (PLHIV) to services and provide significant emotional support. Meeting the demand for care and support for these PLHIVs is a growing concern in India. Current counseling programs focus on prevention and testing of HIV. While this is important, equally important is the array of advanced issues that clients present during follow-up counseling sessions after receipt of positive results.

Positive Prevention has scientifically been shown to be both efficient & effective at preventing secondary infections. Changes in risk behavior of HIV positive persons are likely to have a larger effect on the spread of HIV than commensurate changes in risk behavior of HIV negative persons. There is also a growing body of evidence to support the counseling efficacy among PLHIV since studies show that after receiving counseling, HIV+ individuals are likely to reduce risk more than HIV- individuals. The globally

accepted goals of Positive Prevention are to: prevent HIV transmission to partners; protect the HIV-infected patient from new strains of HIV and other STIs; and to prevent mother-to child transmission of HIV.

ACTIVITIES AND EXPECTED RESULTS

Activity 1: Training of Counselors on positive prevention

CDC, in partnership with India-CLEN, developed the Living Positively with HIV- A Follow-up Counseling Toolkit. In FY2010, TNSACS aims to train Counselors at ART centers, Link ART centers and Community Care Centers on the Follow-up Counseling toolkit. The complex physical, psychological and social vulnerabilities associated with being a PLHIV necessitate the integration of other Positive Prevention into the counseling infrastructure. This training will be complementary to other PLHIV-services related trainings conducted by TNSACS. The 5 -day training will provide skills and tools on issues specific to PLHIV.

ACTIVITY 2: Evaluation of the Toolkit

In 2010, TANSACS in partnership with the USG, will initiate an evaluation of the Toolkit to assess the effectiveness of the Toolkit as a programmatic prevention intervention strategy. Since ART counselors will have more frequent and consistent interaction with PLHIV clients, the evaluation will be done on this group. The specific objective of the evaluation will be to study the impact of the Toolkit on the specific outcomes in PLHIV, such as Improvement in quality of life, Reduction in depression, Reduction in perceptions of stigma and discrimination, Improvement of knowledge and practice of safer sex and Increase in partner notification and testing.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	200,000	

Narrative:

SUMMARY

The USG will continue to provide technical assistance for Strategic Information (SI)/Monitoring and Evaluation (M&E) to TNSACS so that the vast amount of data collected is analyzed, interpreted and use for improving quality of program and appropriate decision making. USG in collaboration with TANSACS, National Institute of Epidemiology (NIE) and U.S.-based university specializing in HIV epidemiology will organize a HIV Epidemiologist Training Program for state (and central) government officials (from all over

the country including TN). The trainees attending this program will be intensively engaged in understanding, analyzing and interpreting data from the MIS of TANSACS as well as GHTM and other state government agencies. They will also be engaged in developing the SI and M& E capacity of the state and district level staff involved in NACP III.

The USG will also continue to provide assistance to the TB/HIV Information System (T/HIS) at the General Hospital of Thoracic Medicine, Tambaram (GHTM) and continue to remain intensively engaged with the Quality Improvement Group at GHTM.

Activity 1: HIV Epidemiologist Training Program:

This has been described in details in the Section on OHSS. The existing disparate distribution of the disease in spite of strong prevention programs in different parts of the country warrant strengthening the capacity for understanding the epidemiology of the epidemic including analysis and interpretation of data within the state AIDS control societies and state government staff in general.

TANSACS and the USG will address the issue of human capacity development in HIV epidemiology and biostatistics. With the support of National Institute of Epidemiology (NIE), TANSACS and the USG will develop a specialized training program in coordination with a U.S.-based university specializing in HIV epidemiology for state (and central) government officials (from all over the country including TN). The agencies/departments deputing the trainees will commit to the deliverables from the staff that would be undergoing the training program.

The following competencies will be expected from the trainees:
• Become part of the HIV surveillance teams at the state or national level (as required)
• Able to use statistical software (as defined by the program) to analyze relevant data from the field/ program
• Able to epidemiologically interpret the surveillance data and prepare reports
• Able to undertake both qualitative and quantitative research studies
• Able to write scientific papers and send them for publications to various peer reviewed national as well as international journals
• Able to conduct good quality HIV epidemiology and data management training sessions for program staff at the district and state level

ACTIVITY 2: Strengthening TNSACS Management Information System (MIS)

Through the HIV Epidemiologist Training Program as mentioned above, efforts will be focused on building the capacity of the newly functional/recruited program divisional staff in TNSACS to analysis and interpret data generated by the state program. The trainees of the program will be involved in building the capacity of the 112 NGOs working in prevention and care programs funded by TNSACS and the refresher training on SI for the relevant staff (approximately 1100) at Integrated Counseling and Testing Centers, ART centers, Community Care Centers, blood banks, and NGOs.

Additionally, technical assistance will through this HIV Epidemiologist training program will help in further refining the annual sentinel surveillance process in Tamil Nadu and will help in addressing more at-risk populations. This activity will continue through FY11. There will be a greater focus on the analysis of existing data to create a scientific body of evidence to assist in program planning.

ACTIVITY 3: Capacity Building for District AIDS Prevention and Control Units (DAPCUs)

Through the HIV Epidemiologist Training program will provide technical assistance to build the SI capacity of these DAPCU teams in collaboration with APAC. The focus will be to strengthen skills on basic public health principles, field management skills, HIV prevention strategies, HIV care and treatment operational guidelines, and monitoring and evaluation skills. Additionally, the USG will work closely with TNSACS to build the SI capacity of the District Health Officers, who will be required to oversee the HIV/AIDS programs in their districts.

ACTIVITY 4: Support to GHTM, Tambaram through TB/HIV Information System (T/HIS)

Over the past decade, Government Hospital of Thoracic Medicine (GHTM) at Tambaram, has established itself as a Center of Excellence in patient care, particularly related to HIV/AIDS and Tuberculosis (TB) care and treatment. This is reflected in the high quality of patient care and outcomes as well as in the high number of patients that seek care there. This has been possible largely because of the dedicated efforts by GHTM staff and its partners towards providing high-quality care and treatment to those infected and affected by HIV/AIDS.

The USG has supported GHTM by establishing the TB/HIV Information System (T/HIS). T/HIS is an electronic health management information system developed to improve the efficiency and effectiveness of care provided to patients and to provide patient and program data that can be used in better program management at the State, and National level. T/HIS holds longitudinal patient records of over 370,000 (10 million patient interactions) patients at GHTM in a comprehensive electronic database. Over the past seven years, the USG and TANSACS have supported in development and implementation of T/HIS through software development, hardware (computers, printers, local area network), and personnel.

While some of the recurring infrastructural support costs in maintaining the TB/HIV Information System (T/HIS) have been taken over by the hospital through national program funding, the USG will continue to support the basic operation of T/HIS by placing data managers and supervisory personnel at GHTM in FY10 and FY11. The USG technical focus will remain on the analysis of existing data to create a scientific body of evidence to assist in program planning.

GHTM has formed a Quality Improvement Committee to develop a strategic plan (5 year) for operational research activities at GHTM. This strategy, which would be based on context-specific needs and in-line with national policy, would serve as a guideline or road map for research activities to be defined, prioritized, and carried out at GHTM. This committee will also provide strategic direction and infrastructure support to the TB-HIV Information System (THIS) currently used for patient record management at GHTM. It includes members from GHTM, TANSACS, the USG and its partners. Specific job responsibilities of this Committee include:

• Develop/ update the research agenda for GHTM (which may include components of NACO research agenda) and promote it
• Develop and carry out a mentoring plan for the researchers in GHTM
• Identify areas for Operationalization and infrastructure improvements to THIS
• Compile and promote the research activities and case studies done/ developed through GHTM
• Identify additional sources (internal and external) of funding and technical support for GHTM research activities.

USG will continue to be intensively involved in the Quality Improvement Committee of GHTM.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	345,000	

Narrative:

SUMMARY

Due to the technical and financial support provided by the USG for technical consultants in TANSACS in past 3-4 years, TANSACS has been able to demonstrate and document successful program management and implementation, which has led to the leveraging of national-level funds by TANSACS to directly fund and regularize in the State program the activities/support activities (partially or fully). This has benefited the mainstreaming of programs like the SHG prevention intervention, monitoring for Integrated Counseling and Testing (ICT) and Prevention of Mother-to-Child Transmission programs, Red Ribbon Club (RRC) programs, operational and maintenance costs at GHTM and M&E systems.

In FY10 and 11, the USG and TANSACS will focus on strengthening health systems by rolling out an

HIV Epidemiologist Training Program. Through this program, efforts will be made to develop human capacity of District AIDS Prevention and Control unit Staff too and organize state to state information sharing workshops. TheUSG will continue efforts to maintain quality while mainstreaming Self Help Group (SHG) HIV prevention intervention programs with the Tamil Nadu Women Development Corporation (TNWDC). The USG and TANSACS will also continue to work closely with the State Department of Higher Education to mainstream Red Ribbon Club programs- the HIV prevention program for college based youth.

ACTIVITIES AND EXPECTED RESULTS

Activity 1: HIV Epidemiologist Training Program:

Significant efforts have been made through the Tamil Nadu state and national program to control HIV Epidemic since HIV virus was first identified in 1986 in Tamil Nadu-India. Through the BSS, the state has been tracking prevalence of the disease and has been able to show a consistent decline, due to its proactive efforts, in ANC HIV prevalence from 1.13% in 2001 to 0.25% in 2007. However, there have been certain districts where the prevalence continues to remain high such as Namakkal, Salem, Krishnagiri, Trichy, Theni, etc. in spite of all the prevention efforts. It has been difficult to comprehend the factors associated with such disparate distribution of the disease in the state. The existing circumstances warrant strengthening the capacity for understanding the epidemiology of the epidemic including analysis and interpretation of data within the state AIDS control societies and state government staff in general.

TANSACS and the USG had a series of discussions to address the issue of human capacity development in HIV epidemiology and biostatistics. The National Institute of Epidemiology (NIE) in Chennai has a successful track record of delivering both short and long term programs in epidemiology and biostatistics and is also a member of NACO's Technical Resource Group for HIV epidemiology. NIE is in the ninth year of conducting Field Epidemiology Training Program (FETP) in India in collaboration with CDC-Atlanta known as Masters in Applied Epidemiology (MAE). Further, NIE launched the ICMR School of Public Health with its MPH program in 2008. TANSACS and the USG have decided to develop a specialized training program in coordination with a U.S.-based university specializing in HIV epidemiology, with NIE being considered as the most appropriate organization to conduct the program.

This training program is being developed for state (and central) government officials (from all over the country including TN) would be deputed full time for the training period from their respective agencies/ departments. The agencies/ departments will commit to the deliverables from the staff that would be undergoing the training program.

The following competencies will be expected from the trainees:
• Become part of the HIV surveillance teams at the state or national level (as required)
• Able to use statistical software (as defined by the program) to analyze relevant data from the field/ program
• Able to epidemiologically interpret the surveillance data and prepare reports
• Able to undertake both qualitative and quantitative research studies
• Able to write scientific papers and send them for publications to various peer reviewed national as well as international journals
• Able to conduct good quality HIV epidemiology and data management training sessions for program staff at the district and state level

The concept of the program will be based on
• Initial 9 months undergoing the basics at NIE along with regular support from faculty from external agency/ university
• In mid part of the course (3rd month onwards), trainees work with TANSACS and other important government health related data either at TANSACS/ GHTM/ NIE or convenient agency. This will continue throughout the training period.
• Trainees would also be sent for field visits for epidemiological investigations to various sites in country and will be expected to assess the situation, interpret and analyze data and prepare reports.
• In the last part of the training (approx. 3 months), trainees will undergo advanced epidemiological sessions, including understanding the newer developments/ systems in U.S., applying the same for data collected/ analyzed earlier and undergo an examination.
• Successful completion of the course will be certified by external university, NIE, CDC and TANSACS.

There will be a technical review committee (including members from key stake holders) which will review the progress of activities on a regular basis and will ensure the quality of the program.

Recruitment of the trainees will be in such a way that over a period of five years, 50 trained HIV Epidemiologist would be available to State and Central Government of India. In the first year 5 candidates will be trained.

ACTIVITY 2: Capacity Building for District AIDS Prevention and Control Units (DAPCUs)

As mentioned in the SI program area, the USG through the trainees and staff of the HIV Epidemiologist Training Program will provide technical support to TNSACS and TSU for capacity building of the DAPCUs. Workshops would be organized by TANSACS to develop skills of District Health Officials as

well as DAPCU staff on basic public health principles, field management skills, HIV prevention strategies, HIV care and treatment operational guidelines, and monitoring and evaluation skills.

ACTIVITY 3: State-to-State Information-Sharing Workshops

To facilitate information sharing and collaboration with other state HIV/AIDS Control Societies (SACS) in FY10, the USG will support TNSACS to organize state-to-state sharing workshops for the southern states (Andhra Pradesh, Karnataka, Kerala, Goa and Pondicherry). Other agencies implementing USG state-level programs will be invited to share their experiences and to identify best practices and strategies to addressing HIV/AIDS in their respective states. TNSACS with the support of National Institute of Epidemiology (NIE) is the ideal SACS to coordinate such workshops due to their experience and history of success. This will provide opportunity to develop skills for good scientific writing and documentation, and epidemiological and public health skills.

ACTIVITY 4: Technical assistance for maintain quality of mainstreaming SHG program

The Tamil Nadu State AIDS Control Society (TANSACS) working in partnership with the Tamil Nadu Women's Development Corporation (TNWDC) supports training of rural women's of Self-Help Groups (SHG) to address health issues and to empower them to become change agents in society. SHGs have also made women financially independent and socially and politically organized. The potential of SHGs to influence health issues has been focused upon and is being used by all sectors of the government to address health and development issues in the community. Women in SHGs are being trained on HIV/AIDS and STIs, communication issues on sex and sexuality and sexual negotiation skills and where to seek services for HIV counseling and testing and STI treatment. TANSACS will continue to provide technical assistance for this training program, delivered by the government, through the SHG movement. TNSACS and TNWDC will continue to work in partnership. The USG will continue to support this initiative of TANSACS through a consultant who will coordinate training, logistics, and monitoring of the program in coordination with TNCDW. In FY10, he will assist TANSACS in planning and implementation of the scale up of the SHG program to the entire state. The consultant will also assist in developing a sustainability plan involving the relevant government agency, TNCDW, to support the program from its own budget. The consultant will independently monitor the program for effectiveness and quality and will assist in revising the modules as required.

ACTIVITY 5: Technical Assistance for mainstreaming Red Ribbon Club Programs

Red Ribbon Club (RRC) is an on-campus and voluntary educational intervention among college youth is

being implemented all over the country with the twin objectives of reducing HIV infection among youth by raising their risk perception and preparing youth as peer educators and agents of change. NACO has recognized the efforts of the USG in development of the Celebrating Life curriculum which is being used to train all the students on HIV prevention. TheUSG, in partnership with TNSACS and the state Ministry of Higher Education, supports this program being implemented across more than 1000 colleges in 14 universities in the state of Tamil Nadu by placing 28 university-level field officers (two per university) and 2 regional managers under the Technical Officer for Youth Affairs of TNSACS with technical support coming from the USG. TNSACS, via NACO and state funding, provides seed funds to each RRC to help facilitate HIV prevention and stigma-reduction programs both in the colleges and outside in the nearby communities. USG support includes curriculum development, training and monitoring and evaluation of RRC activities. In FY10, efforts will be continued to mainstream these activities with the state Department of Higher Education and Department of Youth Affairs.

Some key steps by which the mainstreaming efforts will be continued further through FY10 and 11 are as follows:

• Field Officers will be university based and thus would be supporting universities through colleges under them to implement RRC programs instead of direct implementation as was done earlier.

• Professors and Peer Educators from the colleges would identified and trained to conduct Celebrating Life module training for the students

• RRC C-Life module (developed by the USG) will be introduced as part of students' college curriculum thus ensuring uniform access to life skills and knowledge for prevention of HIV.

• Reporting by the colleges will also be which will further increase ownership

• Generation of Corpus Funds in colleges for RRC so that RRC activities could be continued in the colleges without the financial support of TANSACS.

• Formation of the RRC State level Advisory Committee headed by Secretary Higher Education a senior Indian Administrative Officer heading the State Department of Higher Education which will oversee the mainstreaming activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	25,000	

Narrative:

SUMMARY:

Red Ribbon Club (RRC) is an on-campus and voluntary educational intervention among college youth in Tamil Nadu that started in 2005. It is implemented with the twin objectives of reducing HIV infection among youth by raising their risk perception and preparing youth as peer educators and agents of

change. Each RRC is made up of 10-50 college student volunteers motivated to some degree to address HIV and other sexual health issues among their age group and/or community. CDC, in partnership with TNSACS and the state Ministry of Higher Education, supports this program being implemented across more than 1000 colleges in 14 universities in the state of Tamil Nadu by placing 28 university-level field officers (two per university) and 2 regional managers under the Technical Officer for Youth Affairs of TNSACS with technical support coming from CDC. TNSACS, via NACO and state funding, provides seed funds to each RRC to help facilitate HIV prevention and stigma-reduction programs both in the colleges and outside in the nearby communities. CDC support includes curriculum development, training and monitoring and evaluation of RRC activities. In FY10, efforts will be continued to mainstream these activities with the state Department of Higher Education and Department of Youth Affairs.

ACTIVITIES AND EXPECTED RESULTS

The Red Ribbon Club (RRC) program is an ideal social support platform for youth to understand the myths and misconceptions about sexual health in the context of HIV and gain skills in decision making for protecting their health. There are Red Ribbon Clubs (RRCs) in over 1000 colleges in Tamil Nadu State, with a volunteer strength of above 57,660, reaching over 150,000 students in various higher educational institutions (and an undocumented number of out-of-school youth through community programs). RRC volunteers undergo training using the Celebrating Life curriculum, which is a ten hour package that addresses socio-cultural influences and vulnerabilities to HIV particular to both young adult men and women to HIV. In FY08, this program was endorsed by NACO and adopted as a national strategy and adopted in NACP3. In FY09, plans were developed to mainstream this program within the Ministry of Education so that there is a sustained mechanism to address HIV/AIDS in this vulnerable age group. In FY10, these mainstreaming efforts will be continued.

ACTIVITY 1: Celebrating Life: Curriculum on Sex and Sexuality
The curriculum has been rolled out with urban and rural college youth with supervision by the USG-supported RRC Regional Managers and Field Officers. It includes topics on adolescent vulnerability, HIV/AIDS and STI, gender-based issues/vulnerabilities, life skills and sexual rights and responsibilities. Nearly 787 three-hour Primer and 500 ten-hour curricula have been rolled out in 1023 colleges from FY06-09 and the program will continue through FY10, with the addition of 200 more RRCs in Law, Agriculture, Medical and Paramedical (pre-service) colleges which were not targeted previously.

NACO has endorsed the Celebrating Life curriculum by including it in the NACP3 Operational Guidelines. The USG and TNSACS will provide TA to NACO in the finalization of the guideline by incorporating lessons learned in the field. Additionally, the USG and TNSACS will advocate for mainstreaming the RRC Program and curriculum within the Department of Higher Education and Department of Youth

Affairs. Regional Managers and Field Officers will help TNSACS train 1023 RRC Program officers at district level on the three-hour curriculum and give them an orientation to RRC. Emphasis will also be on identifying trainers from within colleges for training college students and peer educators, in order to create college-based ownership of the program.

By ensuring more trainers are available from within colleges, support provided through field officers will be gradually reduced, which will reflect in the reorganization of the program and the efforts to mainstream it into the GOI throughout FY10-11.

ACTIVITY 2: Peer Education Training and Convention
In addition to peer leaders' conventions, RRC Regional managers and RRC Field Officers will focus on strengthening the team of Peer Educators in every RRC. A curriculum will be prepared, piloted, and implemented for training the peer educators to enable them to organize three to six campaigns in their colleges every year. Each peer educator will reach 10 to 30 peers through peer education. The peer educators training will focus on transitioning the program implementation and reporting to the college students.

ACTIVITY 3: Networking
In order to increase the reach of the HIV/AIDS program to young adults, TNSACS started interactive sessions of community people with college youth through RRCs. College youth will interact with: a) PLHIV to orient them on stigma and discrimination issues, b) Trans-genders to understand the issues faced by sexual minorities; and c) IDUs to understand HIV transmission through a non-sexual route. ICTC counselors will also visit colleges to encourage counseling and testing.

ACTIVITY 4: Community Outreach by RRCs
In FY09 the RRC District Managers and RRC Regional Managers reached out to nearly 35,000 RRC members with the Celebrating Life Curriculum and nearly 15,000 Peer Educators on skills training. The Peer Educators will further reach out to about 150,000 peers. Peer Educators will also reach out to youth outside the college campus through village awareness campaigns and programs on radio and TV, and street theater performances. Community blood donation drives are another way by which RRC staff will reach out to the community and spread messages of safe blood donation. Collaborations will be made with the National Service Scheme (NSS) so that peer educators (who may also be NSS volunteers) are allowed to conduct sessions on HIV/AIDS. This innovative plan will reach out to more than 100,000 NSS volunteers in FY10 and 11.

ACTIVITY 5: Monitoring and Evaluation of RRC Programs
Program indicators and reporting formats will be further streamlined and efforts to capture the impact

made by the peer educators. There will also be a focus on establishing a formal reporting system for colleges for RRC activities (at least on a six monthly basis). Field level staff will be trained to capture these indicators.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	20,000	

Narrative:

SUMMARY

Since 2004 HHS/CDC, in collaboration with the Tamil Nadu AIDS Control Society (TNSACS), has supported the development and operations of state of the art laboratory services at the Government Hospital of Thoracic Medicine, Tambaram (GHTM). In FY08, a senior laboratory manager was supported by the USG to oversee laboratory services and additional five laboratory technicians were hired. In FY09, TANSACS has regularized the positions of the Lab technicians through NACO (Governmentt of India) funding and thus in FY10, the USG will continue to support the senior Lab manager position to maintain quality of lab services. GHTM Lab is also recognized as the State Reference Laboratory and thus Lab Manager would be providing technical and monitoring support for external quality assurance (EQAS) to over 80 ICTCs under their supervision. The USG would also work closely with TNSACS and NACO to expand opportunistic infection diagnosis capability of the SRLs in the country.

ACTIVITIES AND EXPECTED RESULTS

ACTIVITY 1: Support for GHTM Laboratory Services

Since 2004 USG/CDC, in collaboration with TNSACS, has supported the development and operations of state of the art laboratory services at the Government Hospital of Thoracic Medicine, Tambaram (GHTM). The support is particularly strategic as GHTM is the largest HIV care and treatment center in India, currently caring for over 30,000 HIV-infected patients annually, 6600 of whom are receiving ART. GHTM, with CDC support has developed into a national HIV training center of excellence. Each year, GHTM performs 25,000 HIV tests, 20,000 CD4 tests, and 150,000 AFB smears to diagnose TB, as well as basic chemistries and hematology tests for HIV-infected patients. Previous HHS/CDC support has included procurement and maintenance of diagnostic equipment, reagents, renovating laboratory space, operational cost for running the laboratory, regular technical assistance, and the placement of laboratory technicians. As a result, GHTM is recognized as one of the most comprehensive and high quality laboratory in India and also as the State Reference Laboratory for HIV testing. In FY09, TANSACS has absorbed the operational and maintenance costs of GHTM as well as the positions of the lab technicians through NACO (GOI) funding. These were previously supported by USG and thus have been

mainstreamed in the national program.

In FY10 and FY 11, CDC, in collaboration with TNSACS, will continue to support senior laboratory manager to oversee laboratory services at GHTM. This laboratory manager will be responsible for quality assurance/quality control (QA/QC) of GHTM lab services, ensuring timely generation of test results, record keeping and reporting, expanding services, and lab staff management. This senior manager will also assist developing a QA/QC training program for private sector laboratories involved in HIV diagnosis, care, and treatment. S/He will report directly to TNSACS with direct technical assistance from HHS/CDC.

ACTIVITY 2: Role as State Reference Laboratory for HIV testing under NACPIII

GHTM Lab has been recognized as State Reference Laboratory for HIV testing and thus the Senior Lab Manager would be responsible for the supervision and quality assurance of over 80 ICTCs (Integrated Counseling and Testing Centers) labs under their jurisdiction. He will be conducting training of all the lab staff of the ICTCs two times a year and will be carrying out four rounds (quarterly) of EQAS as per the national program guidelines.

ACTIVITY 3: Increasing the diagnostic capabilities for opportunistic infections (OIs) at the State Reference Laboratories (SRLs)

GHTM lab is a comprehensive public health laboratory which not only diagnoses HIV but carries out various hematology, biochemistry and microbiological tests for monitoring HIV and the opportunistic infections associated with it. The USG will continue its efforts in FY10 and FY 11 to increase the capabilities of SRLs for OIs by developing training material as well as conducting trainings for the lab personnel in the Tamil Nadu state (and other parts of the country).

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9196	**Mechanism Name: SAMASTHA-UOM**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: University of Manitoba	
Agreement Start Date: Redacted	Agreement End Date: Redacted

TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 3,292,112	
Funding Source	**Funding Amount**
GHCS (USAID)	3,292,112

Sub Partner Name(s)

Belgaum Integrated Rural Development Society	Bharat Gyan Vigyan Samithi (BGVS)	Bhoruka Charitable Trust
Citizen's Alliance for Rural Development & Training Society	Darbar AIDS Tadegattuva Mahila Sangha	Development Education Service (DEEDS)
Engender Health	Karnataka Health Promotion Trust	Karnataka Network of Positive People
Kempegowda Institute of Medical Sciences	Leprosy Relief Association India	MYRADA
National Institute of Mental Health and Neuro Sciences	Sadhane	Sneha Charitable Trust
St. John's Medical College	Swami Vivekananda Youth Movement	Swasti
UJWALA Rural Developemt Service Society	Vimukthi AIDS Tadegattuva Mahila Sangha	

Overview Narrative

Samastha is a comprehensive HIV/AIDS prevention, care and support project in 15 districts in Karnataka (KN) and 5 districts in coastal Andhra Pradesh (AP). KN and AP have the highest HIV burden in the country and the primary emphasis of the project is on adult care and support in selected districts of KN and AP, with a prevention program focus in rural KN. The Bill and Melinda Gates Foundation (BMGF) has a prevention program focused mainly in urban areas. The Clinton Foundation works in the areas of pediatric care, while the Global Fund supports the community care centers (CCC) through the national program. The prime implementing partner is the University of Manitoba/Karnataka Health Promotion Trust (KHPT), in partnership with several technical and implementing agencies working in close collaboration with National AIDS Control Organization (NACO), the State AIDS Control Societies (SACS) of both states and the District AIDS Prevention and Control Units (DAPCUs).

Key ongoing activities include:
• Targeted interventions with rural female sex workers (FSW) and their regular partners, including peer outreach, condom promotion and linkage to sexually transmitted infection (STI), TB and HIV related services.
• Focused interventions with rural men and women at risk of HIV, through behavior change programs that emphasize partner reduction, condom use, and access to HIV counseling, testing and care services.
• People living with HIV/AIDS (PLHIV) driven facility and community-based care, treatment and support programs with a focus on positive prevention.
• Technical assistance (TA) for scale-up and quality improvement in services through the NACO-supported counseling testing services (CT), antiretroviral therapy (ART), TB-HIV integration and community care centers (CCCs).
• Health systems strengthening: building human resources for health through training in collaboration with the National Rural Health Mission (NRHM), regional supportive supervision and clinical mentorship; and utilization of program learning sites by state and national level players.
• Capacity building of community-based organizations for organizational development, project and financial management.
• Comprehensive strategic information (SI) activities including TA for monitoring and evaluation (M&E), with individualized tracking for FSWs and PLHIV.
• Mainstreaming orphans and vulnerable children (OVC) interventions with the NRHM, the Department of Women and Child Development (DWCD) and the Panchayati Raj Institutions (PRI).

In FY10, the restructuring of the project's geographical focus will increase beneficiary coverage from 41% to 61% of rural sex workers clustered in eight districts of KN. Comprehensive prevention programs for the general population programs will continue in five northern districts, with a focus on reaching men and women with high-risk behavior. Integrated positive prevention and care interventions through drop-in centers (IPPC-DIC) driven by networks of PLHIV will continue in 12 districts.

In FY10, the last year of the Samastha project, direct implementation will be consolidated to move towards increased provision of TA. Samastha support to the national rural link workers scheme (LWS) within NACP-3 will continue. The LWS seeks to connect high-risk populations with HIV services at government health facilities. Learning sites including Bagalkote district for rural HIV programming, Pragathi-Bangalore targeted intervention (TI) for FSWs, Sangama-Bangalore for men having sex with men (MSM), and Snehadaan-Bangalore for care and support will serve as experiential learning sites for state and national level players. The Samastha TA to NACO for research and M&E activities will continue.

In KN, the sustained demand for TA in the areas of CT, ART, HIV-TB activities, capacity building, communication, gender integration, convergence across different health initiatives and strengthening of

DAPCUs will be met. The support to the design and start-up of a university-recognized HIV fellowship course with the Rajiv Gandhi University of Health Sciences (RGUHS) will continue. Other TA to the government including scaling up of capacity building through the project's Regional Training Centers to train doctors, nurses and counselors with HIV team-training, clinical mentorship, and the Samastha HIV e-learning package (HELP) will continue.

In AP, increased priority will be given to TA for scaling up coverage and quality of state funded CCCs, while retaining the focus on community-based care programs for HIV-affected widows and orphans. Experiential learning sites and systems for clinical mentorship will be developed collaboratively with other state level partners.

Samastha has played a leadership role to operationalize convergence at the district level across health systems. It will continue to strengthen the integration of the PMTCT services with antenatal, delivery and postnatal services of the $8 billion NRHM program. It will continue to promote a synergistic use of materials; equipment, logistics and human resources within NRHM and NACP-III for joint trainings of service providers. It will collaborate with the State Institute of Health and Family Welfare (SIHFW) under the NRHM for various training initiatives. For example, the Integrated Management of Newborn and Childhood Illnesses (IMNCI) package includes a revised curriculum to integrate training on HIV, STI, and TB services to participating health care providers. Samastha will continue to build the capacity of the village health and sanitation committees (VHSC) under the NRHM to address gender inequity, and the community-based organizations of PLHIV, FSWs and MSM and the primary health care systems within the state as part of sustainable programming.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Commodities	21,876
Gender: Reducing Violence and Coercion	5,022
Human Resources for Health	563,766

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Child Survival Activities
Safe Motherhood

TB

Budget Code Information

Mechanism ID:	**9196**		
Mechanism Name:	**SAMASTHA-UOM**		
Prime Partner Name:	**University of Manitoba**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	1,148,509	

Narrative:

SUMMARY

The Samastha project focuses primarily on care support and treatment in Karnataka (KN) and selected districts of Andhra Pradesh (AP), the two states with the highest burden of HIV/AIDS. Activities are managed at the district level by University of Manitoba/Karnataka Health Promotion Trust (KHPT) regional staff in Karnataka and LEPRA society in Andhra Pradesh. Engender Health, St. John's National Academy of Health Sciences, NIMHANS, Swami Vivekananda Youth Movement (SVYM), Kempegowda Institute of Medical Sciences (KIMS), Karnataka Network of Positive People and Snehadaan are other implementing partners working in close collaboration with NGOs and the government at district and state levels. The Rajiv Gandhi University of Health Sciences is a proposed new partner.

In FY10, the activities under this program area will increasingly shift from a direct implementing mechanism to one of technical assistance (TA) as the national and state program expands its own care services across the state. Contributions to the national guidelines for the community care centers (CCC) for children and adults, leadership of the technical working group at state level, and partnerships for development of human resources for health will continue. The project's support to select CCC as learning sites to demonstrate delivery of comprehensive HIV services implementing National AIDS Control Organization (NACO) guidelines will continue.

The project supports people living with HIV/AIDS (PLHIV) led HIV care and support services in 12 districts in KN and five coastal districts of AP through 18 community-led drops in centers called Integrated Positive Prevention Care (IPPC) centers which serve as drop-in centers (DIC). Outreach activities with the family centric approach will continue with special efforts to reach out to children and women. Efforts to sustain the coordination between various HIV services in the districts and institutional

capacity building of the State Institute of Health and Family Welfare (SIHFW) under the National Rural health mission (NRHM) will continue. Efforts at quality improvement will be sustained by supportive supervision and clinical mentoring visits. The Samastha project efforts to ensure that more CCCs provide one-stop services for HIV care will continue.

ACTIVITIES AND EXPECTED RESULTS

Activity 1: Providing TA models for Adult Care and Support

a) TA at the national level
TA for NACO in development of guidelines for adult and pediatric care and support will continue. TA for the CCC program in AP through its learning sites, clinical mentorship and quality monitoring and tracking of adult care services through computerized management information systems (CMIS) will continue.

b) TA for Global Fund-supported CCC under the national program
Samastha project will continue to provide TA to the Global Fund supported CCCs in KN through team-based trainings, clinical mentorship and supportive supervision through regional managers and DAPCU medical officers at a facility level. The team -based trainings target doctors, nurses and counselors and focus on the delivery of a comprehensive sequence of care involving task-shifting and task sharing. "Expert patient trainers" (EPT) who are PLHIV trained to simulate case studies are used. On-site clinical mentorship provided periodically by a team comprising an experienced doctor, nurse and counselor provide a model for a change in practice. Regional managers provide the supportive supervision and facilitate linkages required for comprehensive care. Based on simple semi-structured registration and clinic contact input forms, the individualized MIS tracks PLHIV and can generate reports required by the national program. Advocacy with NACO to adopt this computerized system will continue. Additionally, as part of the Technical Working Group at the State, the project will advocate for institutional capacity building of district AIDS control units (DAPCUs) to monitor the CCC for quality improvement.

c) Development of model CCC learning site for quality HIV care and support centers:
The project will support learning sites that will demonstrate delivery of combined CT, antiretroviral therapy (ART) and CCC services within a single institution and CCC as best-practice experiential learning sites for various thematic areas such as orphans and vulnerable children (OVC), integrated care, PMTCT, ART and palliative care. Key elements of the learning sites will be the provision of comprehensive medical, social and other interventions, integrating with community based outreach and monitoring of individuals using a computerized management information system (CMIS). These sites will be used both for training visits of SACS (State AIDS Control Society) officers/directors and technical support unit (TSU) staff, as well as for experiential learning for program implementers. Additionally

participants of the HIV Fellowship course instituted at the Rajiv Gandhi University of Health Sciences (RGUHS) will also be trained at these sites in Karnataka.

d) TA to NRHM and SIHFW to mainstream HIV care:
The project will continue to provide TA to the NRHM and the Karnataka State Institute of Health and Family Welfare (SIHFW) to build the capacity of primary health care providers. The main areas of capacity building for health care providers will be on the integrated HIV-STI-PMTCT-adult care and treatment training package (ITP); infection prevention and reduction of stigma discrimination in health care settings, sexually transmitted infection (STI) and TB services. These trainings will be done in collaboration with District Training Centers under the SIHFW and the regional training centers.

e) Human resources for health
In FY09, the Samastha project advocacy efforts with the state government and the Rajiv Gandhi University of Health Sciences in Karnataka resulted in the approval of the first-ever university-recognized HIV fellowship course in India. The project will continue to provide TA and start-up support through two training sites to ensure that the course successfully gets off the ground. In 2010, efforts will continue to be made to leverage resources to sustain this fellowship on a long-term basis through partnerships with the national program and other international universities.

Activity 2: Provide community-led initiatives for HIV care and treatment services

a) Support to and transition of PLHIV-led IPPCC-DIC for sustainable programming
The project will continue to support 18 IPPC-DIC. Leveraged support from KSAPS and other donors will increase. These centers will shift to the government ART centre sites, yet offer safe spaces for PLHIV in addition to complementing outpatient medical care with psycho-social support, positive prevention, adherence support, home-based care, nutrition and linkages to legal, vocational services and other social entitlements. About 16,000 adults and children will receive at least one care service, while about 12,000 will receive at least one clinical care. Six thousand adults and children will receive cotrimoxazole prophylaxis, and 1,200 will receive TB treatment through effective referrals to government programs.

The management responsibilities of IPPC DICs will be transitioned from NGOs/KHPT to the community-based District Level Networks (DLNs). The project will focus efforts toward transitioning IPPC-DIC into funding by other partners and KSAPS in FY2010.

b) Strengthening the community home-based care
NGO link workers and IPPC-DIC outreach workers will continue to make home visits to provide home-based care to PLHIV and their family members. Coordination with other field level functionaries will be

ensured to avoid duplication of efforts. The focus will be on identifying the social needs of PLHIV and their affected children and ensuring adherence of PLHIV to treatment. About 6,000 adults and children will receive supportive care services through this outreach.

c) Community- based strengthening of linkage and referrals
Linkages between ICTC, ART, IPPC-DIC, RNTCP and CCC will be strengthened through accompanied referrals, follow up and coordination meetings. At the community level, lead NGOs will provide outreach, home-based care and follow up on referrals. Village Health and Sanitation Committees (VHSC) will be strengthened to address stigma and discrimination and respond to care needs of women and children.

Activity 3: Ensure and sustain quality of services

a) Quality through capacity building, supportive supervision and mentoring.
The project will continue to build the capacity of care providers from both within the project and beyond. The five regional training centers' (RTC) capacity to leverage resources and independently conduct integrated STI-PMTCT-HIV care training will be strengthened. Engender Health will continue to provide technical support in quality improvement, HIV-TB and OVC. Clinical mentoring visits will continue by the training partners. St Johns e-learning, Snehadaan's best practice learning site for care, the university-approved HIV fellowship course will offer different forums for human capacity development.

b) Improving infection control in all CCC in KN and coastal AP
The project will continue to do follow up visits to practice and institutionalize protocols for infection control. It is envisioned that all CCC will have a system in place in regard to infection prevention practice and a policy for reduction of stigma discrimination in health care settings.

c) Facilitation of operational research assessments
Although the risk of HIV transmission in long-term married partners is well documented, initial assessments have demonstrated that the use of 'positive prevention' is very limited among HIV infected sero-discordant and concordant couples. In FY09, the project will focus on assessment of barriers to positive prevention and use its findings to advocate for better programming. Additionally, an end term assessment of the impact of the scale up in HIV care which will also include elements of cost-effectiveness of models for care will be completed.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	202,831	

Narrative:

SUMMARY:
The University of Manitoba/Karnataka Health Promotion Trust (UM/KHPT) Samastha Orphans and Vulnerable Children (OVC) program -implemented with technical support partner Engender Health- is a community based approach. It addresses the six core service areas (nutrition, health, education, psychological support, shelter and protection) including the underlying theme of economic opportunity strengthening to ensure sustainability at the family unit. The program adopts a family-based approach to ensure sustainability in the child's unit/setting. The focus is on: building the capacity of the family, developing community safety nets and work with national, state and local government schemes to strengthen systems to address OVC needs. This ensures access to healthcare, nutrition, education services and builds community systems to safeguard OVC protection and legal issues. The target population will include all children (<18 years) orphaned and/or affected by HIV and AIDS, their families/ caregivers and communities in the 12 Samastha districts in Karnataka and in one district in coastal Andra Pradesh (AP). It aims to reach 3,000 OVC with PEPFAR funds. The OVC program is comprehensive and adopts increased data development for strategic planning, systems strengthening, policy development, community support and coordination, and quality assurance in service delivery.

Some of the successes of the program thus far include: the enrollment of a high number of OVC into the Samastha program; the development of different care models including community foster care, community short stay homes and community local body participation in care support; significant leveraging from donor, government and community support for basic needs of OVC; and the enhanced quality of clinical care through facilitation of HIV integrated management of newborn and childhood illness (IMNCI) package in Karnataka. Additionally, a mechanism has been developed for estimation of OVCs at the district level which is now used at the national level. It has also work to establish the participation of key government departments in m to the needs of OVCs.

However, challenges still exist. These include:
• Inadequate resources to provide the full-fledged support for the large numbers of OVC in the program.
• Inadequate human resources to ensure child specific planning and intervention as per the requirement of the child
• Working with aged caregivers to provide quality care for their children
• Attitudes of stigma and discrimination in the rural population

ACTIVITIES AND EXPECTED RESULTS:

ACTIVITY 1: Increasing access to quality services for orphans and vulnerable children (OVC)

A) Leverage funds from different government and private sources
The OVC program leveraged services and support from various donors, government and philanthropists to cater to the nutrition, education and transport needs of OVC. This includes secondary and tertiary medical care. Project staff have generously contributed to continuous support for OVC interventions. The program will continue to source out funds from other entities and to scale up government services. Priority to actively ensure that all children eligible for ART access ART services in a timely manner will continue. Life Skills Education (LSE) will continue to be rolled out to build the resilience in OVC.

B) Strengthen family/household capacities
The OVC program recognizes that the success of sustainable quality care of OVC is directly related to the development of the capacity of the family / household. The program will continue to train the caregivers to provide quality nutrition, education, shelter, access social entitlements in case of need and safeguard their rights. 300 caregivers will be trained in home based care, home care kits and ART adherence. They will also be trained to access ART services and to provide better care for their children. Vocational training will be leveraged to address their economic well-being.

C) Develop community support and coordination
The implementing nongovernmental organizations (NGOs) and community-based organizations (CBOs) will actively engage the community -including Village Health and Sanitation Committee (VHSC) and community volunteers- to scale up support systems and define policy to protect and support the basic rights of OVC. The community will be involved in the reintegration of OVC within their community. Community support for nutrition, education and travel requirements will continue and innovative strategies like community farming will be explored.

ACTIVITY 2: TA for convergence of government departments including policy development for OVC

The Samastha program works with various levels of government to provide system strengthening at the state and the district level. Engender Health has been part of the peer group review of the National guidelines for Care and Support for Orphans and vulnerable children. Karnataka Health Promotion Trust (KHPT) will pilot the NACO OVC model initiative in the two districts of Bagalkot and Belgaum. This initiative will explore mechanisms of ensuring that basic needs of all OVC including nutrition, shelter,

psychological needs, medical care and legal support are met through community based mapping and identification of children and the resources to meet their needs, linkages with the different government schemes and programs and monitoring and supportive supervision to ensure quality.

The Samastha team will continue the process of technical support and system strengthening with the Karnataka State Institute of Health and Family Welfare (SIHFW) in rolling out the HIV integrated management of newborn child infections (IMNCI) package through Engender Health.

The program has been responsible for leveraging a significant amount of funds ($ 0.25 million) for the Department of Women and Child Welfare Department and will continue to work with the department to provide technical support in program design and implementation to cater to the nutrition and shelter needs of OVC in Karnataka. An attempt to develop a convergence strategy between the departments of women and child development, education, food and civil supplies and housing is being sought to catalyze an appropriate response for OVC.

ACTIVITY 3: Address quality assurance in service delivery

Activities will be monitored with the help of the management information system (MIS) and qualitative reports, site visits and interaction with the caregivers and children under the program. Facilitative supervision and program supportive monitoring will enhance the technical support at the field level and bring about ongoing program quality improvement. The child health record that has been designed is now available in all the districts and this will serve as a tool for monitoring the child's status. A family assessment tool has also been developed to identify family units that are most in need. This tool will be used in all Samastha districts to identify and link family/child-headed units with government and nongovernment schemes for OVC and their mothers.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	151,011	

Narrative:

Summary

The focus of program activities under this budget code narrative was initially on supporting the scale up on ART services in the private and non-government sector in Karnataka (KN). This was done to complement the National AIDS Control Program phase III (NACP-3) scale up in the government sector. The current focus is on technical assistance (TA) for this scale up in coverage, comprehensiveness and quality of the antiretroviral therapy (ART) services. Samastha project will continue to support three sites

which provide ART; St. John's Medical College and Hospital (SJMC), Kempegowda Institute of Medical Sciences (KIMS) -which are NACO designated ART centers- and at the Swami Vivekananda Youth Movement centre at Sargur -which is designated as a link-ART center at sub-district level. These sites will not only be service delivery points, but will also be involved in building the technical capacity of care providers for ART services across the state, as learning sites and for implementation of the HIV Fellowship course.

The technical consultant supported at the state level since the FY08 will continue to be supported under Samastha. The mentorship for counselors in ART centers initiated in FY08 will continue. Samastha will continue to input into the adult treatment initiatives, the linkages with TB-HIV, ICTC and TI and the leveraging of other supportive services through the technical working group created for this purpose. The Rajiv Gandhi University of Health Sciences (RGUHS) will continue to be supported with TA to implement the HIV Fellowship as well as to leverage funds from other sources to sustain the effort. A commitment has already been made by the government at the state level to absorb the successful candidates from this fellowship into the ART centers.

An internal analysis showed that lost to follow up (LFU) occurs at the following three levels:
• From the CT site to registration at ART center,
• Between pre-ART registration and initiation of ART and
• After the patient has been put on ART

Samastha project had initiated district-level coordination meetings involving all prevention, treatment and care and support partners in FY08. These meetings are now being convened by District AIDS Control Unit (DAPCU) medical officers. At the meetings, lists of loss to follow up of those on ART are shared with the concerned CCC and Integrated Positive Prevention and Care –Drop in Centers (IPPC-DIC) field staff. This has helped trace and retrieve a number of LFU cases. The challenge to reduce loss to follow up and death rates among those on ART will be addressed through coordination and collaboration of all HIV workers at the field level; health system strengthening efforts with a focus on strengthening the role of the DAPCU; and better monitoring and evaluation to explore the determinants of non-adherence and cause of death. Direct community level mobilization of PLHIV by Samastha field level workers will focus on improving access for women and children for treatment services, improved quality of care through training programs, clinical and counseling mentorship through St John's Medical College and Hospital and the implementation of the Client Oriented Provider Efficient (COPE) tool by Engender Health.

Activity 1: TA at the state level

A) Consultant Support

The consultant for ART services at the Karnataka State AIDS Prevention Society (KSAPS) will continue to be supported under the Samastha. Additionally, a technical working group appointed by KSAPS will continue to provide TA to determine locations, establish links, leveraging of resources for comprehensive care and for strategies to reduce the loss to follow-up at the ART centers. Training and capacity building plans for ART services will be drawn up by this group. The location of additional ART centers will be decided based on evidence gathered from triangulation of data available with KSAPS and other studies. The links with CCC, CT , HIV care sites implemented by positive group networks, NGOs working with targeted interventions and the rural link worker scheme will be strengthened through district level coordination meetings convened by the district AIDS control unit (DAPCU) and facilitated by Samastha. Operational guidelines development for IPPC-DIC, technical support and review meetings will continue to be the responsibility of the technical working group. ART services need to be complemented with adequate nutrition and other measures to increase accessibility. Location of link ART centers, leveraging nutrition from other sources and departments and advocating for free/concessional travel will also continue to be guided by the technical working group (TWG).

B) Improve the quality of service delivery at ART Centers
The project will continue to build the capacity ART center staff through continued e-learning opportunities. The HIV fellowship course will create the pool of trained doctors who could be offered positions within the ART centers. The ART sites will be provided ongoing technical support and supervision by Engender Health and KHPT. The site staff will be trained to use COPE© Quality Improvement tools to ensure high quality ART services at the site. Samastha will continue to support the mentorship of ART counselors to perform this function.

C) Human Resources for Health
Advocacy efforts made by Samastha project with the state government and the Rajiv Gandhi University of Health Sciences in Karnataka resulted in the approval of the first ever university-recognized HIV Fellowship course in India. Samastha will continue to provide TA and start-up support through its training sites to ensure that the course successfully gets off the ground. In FY 10, efforts will continue to be made to leverage resources to sustain this fellowship on a long-term basis through partnerships with the national program and other international universities.

Activity 2: Complement government ART services with ART services in non-government sector

In FY09 and FY10, the project will continue to provide significant site specific support in the form of personnel. A plan will be drawn up with the institution to absorb these personnel as regular staff of the institution in a phased manner. These sites function both as service delivery points for antiretroviral treatment and for hands-on experiential learning. 300 adults and children will be newly enrolled on ART,

1,000 will receive ART during the year and 700 will receive ART for more than 12 months.

Activity 3: Establish reduced rates of lost to follow-up (LFU) cases of uptake of HIV related care and treatment services

a) Field based outreach and community-based networks

Samastha project staff will continue to provide field-level tracking of PLHIV on ART and facilitate transportation to the ART center for timely follow up of both patients on ART and those registered as pre-ART. Additionally, peer outreach workers and link workers (LW, a cadre of workers tasked to link prevention sites with care and support and CT services) will be trained to support post-test counseling and follow up for ART registration for those testing positive. Attention will be paid to ensuring that pregnant women testing positive are followed up to get registered and access ART services. Those on government provided ART who have been lost to follow up will be traced and retrieved onto ART services by link workers covering rural areas, peer outreach workers of the PLHIV- led drop-in centers (DIC) in villages not covered by the LW scheme and by the community care centre (CCC) outreach workers in the urban areas.

b) Computerized individual tracking system (CMIS) for effective monitoring of LFU

In FY10, Samastha will support a NACO request to develop CMIS software that facilitates the individual tracking of uptake of services from the time of diagnosis at the ICTC level. Additionally, operational research to understand causes of high death rate among those on ART, that will be completed in FY09 will be documented and disseminated in this year.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	36,064	

Narrative:

SUMMARY

The Samastha project will continue to implement a modest CT program with increasing focus on provision of technical assistance (TA) for efficient delivery of quality CT services and linkage of CT with other prevention and care related interventions.

Under the National AIDS Control Program – III (NACP-3), there was a significant scale up in the number of CT throughout the country. Karnataka (KN) now has 561 full-fledged CT sites in the government sector, 50 in non-government settings under the public private partnership initiative and 30 mobile CT

sites. It is planned to launch integrated CT services under the National Rural Health Mission (NRHM) in at least 596 "24-hour" primary health care (PHC) centers by early 2010.

In FY08, district supervisors were appointed by the state to provide administrative support to the CT services as part of establishment of the decentralized district AIDS control Units (DAPCU). The Samastha project provides TA for the capacity development of the district supervisors through in-service training and supervision.

Since FY08, the Global Fund supports a resource pool of trainers and mentors for the CT counselors, with Bangalore University serving as the regional training centre. Hence, Samastha will transition out of service delivery and supportive supervision of CT sites. However, on request from the state government, the project will develop two of the existing CT sites as model learning centers for KN to showcase optimal use of Standard Operational Procedures (SOP) and adaptation of NACO guidelines. These sites will be linked to the existing counseling training institutes supported by the Global Fund initiative to serve as on-the-job training opportunities for integrated counseling and testing center (ICTC) personnel including laboratory technicians, counselors and doctors.

A TB-HIV intensive program was rolled out in FY08. Under this program, all newly diagnosed TB patients are also offered HIV testing and counseling. Samastha provided TA to the implementation and scale up of the TB-HIV initiative. Currently the coverage of CT services to an annual estimate of 55,000 newly diagnosed TB patients has increased from about 10% to more than 50% in the state. The project will continue to provide TA to support this initiative.

STI clinics under NACO have been approved to have a counselor. TA is provided for the capacity development of the counselors in the STI clinic to ensure effective provider initiated counseling and testing of all STI patients at the ICTC.

The project will continue to work in close collaboration with NIMHANS and KSAPS to strengthen the delivery of quality CT services.
Some of the challenges that persist include:
• Poor quality of services and laboratory testing.
• Poor forecasting and inventory management within procurement systems.
• Inadequate access and coverage of female sex workers and transgender men who have sex with men with HIV counseling and testing services.
• Inadequate links between the CT, TB and ART services.

ACTIVITIES AND EXPECTED RESULTS

Activity 1: TA for Institutional capacity building for quality CT service delivery

a) Development of model CT learning sites (LS)
This activity is a continuation of initiatives under PEPFAR funded Samastha project that commenced in FY09. Two LS will be initiated one each in north and south Karnataka. In collaboration with the Global Fund supported training institution developing cadres of counseling mentors, the USG supported LSs will provide hands-on training and skills to complement their knowledge. These sites will aim at achieving all the quality and quantity indicators of an effective ICTC program such as the use of standard operating protocols, external quality assurance for laboratory tests, links with sexually transmitted infection (STI), TB, antiretroviral therapy (ART), community care centers (CCCs) and targeted intervention (TI) programs and services and a computerized MIS system that links different services. The lab technician, counselor and medical officer at the LS will be trained to become efficient trainers and facilitators. A total of 300 clients, male and female will be reached with CT services using PEPFAR funds at these two sites.

b) Improving the quality of CT services
Tools for onsite supportive supervision and mentoring for doctors, counselors and laboratory technicians will be developed and pre-tested at the LS. The supportive supervision tools will measure client intake, stigma and discrimination and quality of counseling services and testing records. District supervisors will then be trained in the use of these tools through the Samastha project which provides TA to the induction, refresher and other trainings for district supervisors. Periodic client exit interviews will continue to be undertaken to identify training needs for development of refresher course curricula. One batch of 30 district supervisors will receive in-service training in the use of supportive supervision tools. TA will be provided for implementation of NACO recommended quality assurance mechanisms such as EQAS. A quarterly newsletter will continue to be published to highlight new guidelines, achievements, success stories and challenges faced through a case-based approach.

c) Logistic management information system (LMIS)
The LMIS in place at KSAPS will be sustained to support procurement, distribution and projection for the requirements of HIV test kits and supplies.

Activity 2: Expanding Access to quality CT Services for most at risk populations (MARPs)

As a national strategy CT sites are expected to undertake provider initiated testing for all patients with STI, TB and for pregnant women. However, MARPs will have to be reached beyond the walk-in (voluntary) clients. To reach out to MARPs it is essential to make CT sites more friendly and accessible. Samastha will conduct one 'Training of trainers (TOT) program for 30 participants and the roll-out will be

done through leveraged funds from Karnataka state AIDS Control Society (KSAPS) and other sources and monitored through Samastha.

Mobilization of MARPS to test at CT centers will complement NACO's approach on provider initiated testing. Clients will be mobilized through NGO outreach teams including female sex workers (FSWs), peer educators, link workers and men who have sex with men (MSM) outreach activities and through outreach work by the counselors. Peer educators will be trained and encouraged to get to know their own HIV status. They will then be supported to accompany other peers to access CT services. At least 6,000 FSWs will be reached with CT services at least once during the year. Regular outreach to TI clinic sites from existing ICTC is already in place in a few districts. This will continue to be facilitated in all Samastha districts in close coordination with the DAPCU. Those newly diagnosed with TB and STI will also be offered HIV counseling and testing. Links with the nearest TB facility will be developed for cross referrals.

Activity 3: Facilitation of convergence and mainstreaming activities to increase uptake

To link the sites effectively with existing prevention and care services in both government and non government settings, outreach from the CT to targeted intervention sites for FSW and MSM-transgender sites will continue. This helps to increase the accessibility and coverage of counseling and testing services for those most at risk for HIV, but otherwise marginalized. Link workers (LW- a cadre of community based workers tasked to link CT and ART services at prevention sites) and peer outreach workers from the people living with HIV/AIDS (PLHIV) led drop in centers (DIC) placed at select CT sites will be trained to support post-test counseling.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	123,017	

Narrative:

SUMMARY:

The University of Manitoba/Karnataka Health Promotion Trust (UM/KHPT) Samastha program will continue the Pediatric Care and Support activities implemented with technical support partner Engender Health. The program caters to the needs of institutional based children, while addressing the core components of nutrition, shelter, protection, health care, psychosocial support and education. This initiative will continue to provide quality HIV care services at facility-based care units for children in the six core areas addressing access to health services including immunization, facilitate social entitlements including government schemes and community-mobilized support. The program caters to issues of protection and shelter services as well as capacity building of caregivers. The initiative is implemented

with the principle of reintegrating these children into to their communities.

ACTIVITIES AND EXPECTED RESULTS:

Activity 1: Accessing quality care services for institution-based children

Through these activities, four facilities will be supported in Karnataka and one in coastal Andhra Pradesh. The facility-based children will be provided with quality care that addresses the six areas and these primary direct services will reach at least 200 orphans and vulnerable children (OVC) with overall care and 150 OVC (see narrative on OVC) with clinical care. Additionally, these centers will also serve as referral units for the transition stage of home and foster-based care models.

Nutrition assessment activities are implemented including regular monitoring and capacity building related to addressing malnutrition through medical services. Leveraging of nutritional support from the local to state and national level will be explored.
Healthcare, including regular monitoring for opportunistic infections (OI) and initiating assessment for ART are carried out and linked to government ART centers. Other government services including ICTC, TB DOTS and immunization are facilitated.

Various approaches are being facilitated to address educational needs of these children through regular school systems to open school curriculum. Strengthening of local government education systems and schemes catering to the needs of children will be prioritized. The program will build on the activities to facilitate vocational training opportunities for older children that results in a sustainable livelihood skill set. Additionally, a value-based educational system is being explored in the facility-based settings.

ACTIVITY 2: Quality Improvement of OVC Services:

The program enhances skills through capacity building of the three specific target groups which include the counselors, clinical team and the support staff at the centers. Capacity building addresses an array of themes like assessment of nutrition, psychological well being and child centered communication and child participation, education options, health including home-based care.

The pediatric HIV and ART skills of the clinical team that have been developed through the integrated HIV-STI-PMTCT package training for health care providers will be enhanced through mentorship and supportive supervision. Life skills education (LSE) activities will be sustained and new age specific groups will be formed as the adequate numbers are met to initiate the activity in these pediatric care and support centers. About 200 children will be reached with the LSE package.

Quality assurance at these units will be monitored and assessed through a management information system (MIS) and qualitative narrative reports as well as mentoring site visits and supportive supervision.

ACTIVITY 3: Technical assistance (TA) at national and state level:

The project will participate in the national pilot to operationalize the USG supported operational guidelines on implementing quality OVC programs. Two districts will be developed as learning sites in Karnataka and one in AP. These projects will demonstrate how pediatric care is mainstreamed and linked to existing institutions in government and non-government sector to address clinical care, nutrition, education, shelter and protection needs of OVC, reaching out to children in both urban and rural areas.

ACTIVITY 4: Leveraging from the other national health system programs implemented by Department of Women and Child Development (DWCD), NRHM and by the private sector for child care:

Samastha project has successfully leveraged Indian rupees 10 million (about $ 0.25 million) from the state government to the DWCD to meet the immediate nutrition and travel needs of children and women infected and affected by HIV. TA will continue to guide the DWCD to leverage support from the departments of education and food and civil supplies and from its own integrated child nutrition program.

Through leveraging support from the private sector such as the Deshpande Foundation and K2 solutions, children have been placed in foster care units that enable siblings to stay together irrespective of HIV status, under the care of an affected widow. About 300 children are covered under this initiative.

In an effort to mainstream pediatric care, the Village Health and Sanitation Committees (VHSC) are being galvanized to take responsibility and ownership for widows and children infected and affected by HIV. About 300 VHSC will be trained on OVC care and support.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	242,640	

Narrative:

SUMMARY

The main objectives of the program activities under this technical area in FY10 are (1) to sustain quality of program generated output data; and (2) to build capacity of the partner organizations and State AIDS Control Societies (SACS) of USG priority states to analyze data for evidence-based programming.

The Samastha project focused on developing and implementing a web-based computerized management information system (CMIS) for the USG supported link worker prevention program for rural female sex workers (FSW) and high risk individuals in Karnataka; and for the care and support program in Karnataka (KN) and Andhra Pradesh (AP). While the Global Fund supports the implementation of care services through community care centers (CCC) under the national program, the USG supported Samastha project has provided technical assistance (TA) in the USG priority states for developing a monitoring and evaluation (M&E) framework, implementing web-based CMIS and capacity building of the program staff. Additionally, the project has provided TA to the national program on data management and analysis and mentoring visits to the Global Fund supported CCC. As the national AIDS program has rapidly scaled up services in counseling and testing (CT), antiretroviral therapy (ART), community care, and prevention for MARPS, the quality of data continues to remain a challenge. While quality maintenance of source documents in settings with high client volumes and inadequate time for on-time recording is a well documented concern, staff competency and staff attrition are other factors impeding data management and optimal use of strategic information (SI).

The USG-supported CMIS developed under the Samastha program supports a unique tracking system for long-term target groups, including FSW and people living with HIV/AIDS (PLHIV) and orphans and vulnerable children (OVC). Based on the ease of generating periodic reports from the CMIS developed in Samastha that involved management and analysis of huge data-sets, National AIDS Control Organization (NACO) has requested TA for scaling of the CMIS at the national level.

In FY10 the SI component under Samastha project will focus primarily on provision of TA to the national program for optimal use of SI in program management and monitoring.

ACTIVITY AND EXPECTED RESULTS:

ACTIVITY 1: Improving quality of data through regular data quality audits and analysis of CMIS data for results based performance.

A) Conduct of regular data quality audits:
This is a quarterly activity and will be carried out at the district levels. Tools for regular audits are administered by a data quality audit team comprising the regional manager, deputy director (zonal) and zonal M & E officer who visit the district level entities. The audit team will randomly select records of CMIS and cross verify with source documents.

B) Decentralization of knowledge management at district level:

The zonal CMIS officer and the regional manager will be trained to share the district level CMIS data with the district-level implementing partner in monthly review meetings. A computerized dashboard indicator report with detailed district, sub-district and sub-partner level analysis of coverage, time-trend analysis will facilitate analysis.

C) Clinical mentorship and supportive supervision to ensure data capture:
The Samastha project uses only two input forms for adult care and treatment initiatives; a one time registration form and a clinic encounter form. The form has different elements based on a comprehensive sequence of care and includes assessments of clinical stage, nutrition, TB status, family planning, ART adherence, positive prevention and management of opportunistic infection (OI). Clinical mentorship and supportive supervision will use role-modeling, task shifting and task sharing as means to address this challenge.

ACTIVITY 2: Sustaining capacity of the partners to use evidence-based planning using program data

A) Monitoring program coverage and quality assurance
In addition to the PEPFAR targets, Samastha has devised internal milestone indicators to monitor the achievements of the program. The milestone indicators are denominator-based where the denominators are calculated on the basis of projected target group population in the operational area. The milestone indicators are sub-indicators of the PEPFAR indicators. In addition, some indicators are introduced to monitor most-needy sub-groups in the target population. Every quarter the M&E unit presents district-level analysis to the program directors and deputy directors and the major focus of the next quarter is decided. In FY10, 60 participants will be trained on data triangulation using data from multiple sources (Program data and data from public sector HIV/AIDS program).

B) Measuring the reach and effect of communications on target audiences
This activity constructs communication messages on the basis of results from the segmentation study for high-risk individuals, female sex workers (FSWs) and PLHIV. An output tracking survey will be carried out in every quarter to assess the effectiveness of the communication messages and the messages will be modified on the basis of results from output tracking survey.

C) Operational research to enhance knowledge about program implementation and to identify major opportunities and gaps in the program design
The operational studies include (1) effect of formation of income generating self-help groups (SHGs) on health status of PLHIV (2) determinants of nutrition among children infected and affected by HIV (3) factors leading to lost to follow-up cases on ART.

ACTIVITY 3: Conduct assessments to monitor outcome of the program in its last year of implementation

A) Evaluating program impact on risk behavior
The third round of Polling Booth Surveys (PBS) will be carried out to study change in sexual risk behavior in the general population as well as among FSWs. PBS is a simple evaluation mechanism to provide confidential self-administered assessments of behavior change. The sample population is guided through a set of structured questionnaires for behavior change, for which they 'poll' answers on the spot using a polling booth, assuring self-administration and confidentiality. In the general population, the PBS will be done among six demographic groups in about 900 villages. Among the FSWs, there will be a minimum of ten polling booth sessions per district, with ten participants in each group. In FY10, additional sample will be drawn from Stepping Stone participants groups from the program village to evaluate the effect of Stepping Stone session on the high risk individuals. The stepping stone is a behavior change communication-training module for rural high risk individuals.

B) Monitoring improvements in the quality of life of PLHIV
As part of studying the impact of the program on PLHIV's quality of life, in terms of components such as physical, social and psychological well being, access to and effectiveness of services provided, and experience of stigma and discrimination, this study will be conducted in FY09 for which 200 PLHIV subjects will be included in the year's assessment. Informed written consent will be obtained from the PLHIV, ethical approvals will be obtained through St John's Medical College and questionnaires are administered by trained interviewers. The study will have both a qualitative and qualitative element. There will be no collection of biological samples for the study. However, available results of relevant tests will be used in the analysis (e.g. CD4 count)

C) Measuring and documenting impact and cost efficiency of the program
As part of a final evaluation in the last year of Samastha project, this new activity will triangulate various data sets to identify both the impact of the Samastha project within different districts, and identify best operational models of program implementation. The proposed assessments will help to derive the operational cost of a district-wide model for comprehensive HIV programming.

ACTIVITY 4: TA for capacity building of the SACS establishing "One state-level M&E system"

A) TA to NACO and State:
The Samastha project has responded to multiple requests from NACO including a) to configure a CMIS to capture individualized data from the time of diagnosis at CT sites to ART centre, b) to triangulate data to understand the epidemic disease pattern and transmission dynamics within a district, c) to develop a CMIS and M&E framework for the LW scheme. Samastha project has already shared the CMIS package

developed for HIV care, treatment and support interventions with NACO and other states. Advocacy for the "one state-level M&E system" will continue. At the state level, two workshops will be conducted to train persons on the triangulation and use of data for program planning.

B) Dissemination of lesson learned with program stakeholders
This is an ongoing activity wherein the experiences of planning and implementing a rural HIV/AIDS prevention, care and support program will be documented and disseminated to a wider audience including NACO, Karnataka State AIDS Prevention Society, Andra Pradesh state AIDS Control Society, other national and international agencies involved in HIV/AIDS prevention, care and support programs, academicians and community-based organization. The method of dissemination includes seminars, publication of manuals and reports, presentations in national and international conferences as well as publications in peer-reviewed scientific journals.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	846,372	

Narrative:

SUMMARY

A significant thrust of the Samastha project is the provision of technical assistance (TA) for HIV-related policy development for the state governments, primarily the Karnataka State AIDS Prevention Society (KSAPS), the Andhra Pradesh AIDS Control Society (APSACS) and the partner nongovernmental organizations (NGOs) and community-based organizations (CBOs (including people living with HIV/AIDS (PLHIVs) and sex worker networks). TA is aimed at improving the enabling environment for HIV programs, mainstreaming HIV programming into larger development initiatives, galvanizing political and popular support for HIV policies and programs at state and district level, and capacity-building of government and non-governmental organizations to participate in and lead policy development. Capacity building and strengthening of social structures includes training at various levels from field-based outreach to government personnel at KSAPS.

Samastha works with structures at state, district and village-level to help build the capacity of members for an enhanced and sustainable response to HIV/AIDS. In line with the planned decentralization of HIV programming to the district level as part of National AIDS Control Program III (NACP-III), District AIDS Prevention and Control Units (DAPCU) are now set up in all 29 districts in Karnataka. In coastal Andhra Pradesh, the process of recruiting is ongoing. Village Health and Sanitation Committees (VHSC) for mainstreaming under the National Rural Health Mission (NRHM) are established in most of the villages.

ACTIVITIES AND EXPECTED RESULTS:

ACTIVITY 1: TA for HIV-related policy development and mainstreaming of HIV

Samastha continues to provide TA to the state government departments including KSAPS, the NRHM, the Departments of Women and Child Development, Education, Social Welfare, Transport and Food and Civil supplies to develop a policy and response to PLHIV with a focus on extending social entitlements such as widow pension, housing, ration cards, voter identity cards, nutrition, education, vocational education and training to vulnerable women and orphans and vulnerable children (OVC).

ACTIVITY 2 TA for human resources for health

Samastha continues to conduct in-service training for a number of health care workers at different levels and for different roles.

About 30 district supervisors and supportive supervision teams (SST) will receive in-service training to provide ongoing TA and supportive supervision to counselors within counseling and testing (CT) sites. 30 doctors, nurses and counselors will receive training on mentorship to provide clinical mentorship to doctors, nurses and counselors in care settings on opportunistic infection (OI) management and antiretroviral therapy ART across all districts in Karnataka and coastal Andhra Pradesh.

TA for the in-service training of the DAPCU medical officers will continue from Samastha. One batch of 30 DAPCU medical officers will receive in-service training on data analysis for HIV program planning.

The National AIDS Control Organization (NACO) requested three Samastha project sites to serve as a Learning Site (LS) which will be accredited by NACO as a strategically positioned training site. They will demonstrate proven field success, cost-effectiveness, community participation, and tangible outcomes. Formal training followed by hands-on experiential learning and onsite mentorship in the field will focus on specific thematic technical areas listed below.

Sangama: prevention programming with most at risk populations (MARPs) men who have sex with men (MSM) and transgender people;
Swati Mahila Sangha and Swasti: rural prevention programming with FSW;
Bagalkot: an integrated rural HIV prevention and care programs, including link worker scheme; and
Snehadaan: care and support for PLHIV and OVC.

In coastal Andra Pradesh, four community care centers (CCC) will be strengthened in different thematic

areas to function as LS for integrated HIV care, TB-HIV integration, and PMTCT programs and for orphans and vulnerable children (OVC). At least 200 program implementers and 100 clinical care providers will receive hands-on field level training and exposure at these LS.

ACTIVITY 3 TA for institutional capacity building

A) TA at NACO level
Samastha provides need based TA to NACO. NACO recognized Bagalkote as a LS of the country for its own nation-wide link worker (LW) scheme, cadre of community workers tasked to link CT and HIV services. Samastha will continue to provide TA for computerized management information systems (CMIS) to track clients from CT sites to ART centers.

B) TA at state level:
Samastha will continue to support the state level consultants for ART, TB-HIV and integrated counseling and testing center (ICTC) services at KSAPS. TA is provided for ongoing training needs of DAPCU. The logistic management information system (LMIS) system to ensure the flow of data to KSAPS, management of supplies and an inventory of kits and consumables will continue to be supported and maintained.

C) TA for civil society:
Capacity-building of Samastha NGO and CBO partners, as well as partners of KSAPS, began in FY07. About 60 NGOs/ CBOs leaders will receive in-service training and ongoing support on financial management, management of drugs and commodities, and linkages with supportive services for the community. The PLHIV-led drop-in centers will also receive ongoing support for financial and human resource management, for expanding their membership base, for leadership training, and management of drugs and commodities and program management. Training support for networking and advocacy with other stakeholders to promote access to supportive services and for 'positive speakers' to represent their communities in various forums continue.

The project will support a local FBO, Snehadaan to provide TA to the Global Fund supported CCC across Karnataka for quality improvement. Snehadaan will train 100 staff for experiential hand-holding in-service training for project managers, clinical and outreach staff, will conduct quarterly partner review meetings and provide technical assistance with project management, financial management and monitoring and evaluation issues.

The model of integrating ART and CCC services within the same institution in non-government medical colleges will continue to demonstrate a workable model for public private partnership with the NACO.

This model is implemented at St John's Medical College and Hospital and Kempegowda Institute of Medical Sciences, in Bangalore. Again integrating HIV care within existing health care institutions will be the model for demonstration to the national program at SVYM, Sargur, and Mysore. These will be learning sites for the 10 HIV fellowship participants.

St John's Medical College partnered with the WHO to adapt the Integrated Management of Adult Illness (IMAI) module for India and will continue to strengthen the capacity of 5 regional training centers to conduct similar training. 150 clinical care staff will be trained using the team approach. Pending approval from the National Rural Health Mission (NRHM), this training will be rolled down to the primary healthcare center (PHC) level to expand HIV care to the village level. The Samastha HIV e-learning package (HELP) will continue to be expanded to reach out to 300 doctors in the state.

D) TA to institutions engaged in human resources for health:
Samastha will continue to provide technical assistance to the Rajiv Gandhi University of Health Sciences (RGUHS) to initiate special courses on HIV-TB care. Apart from support for the HIV Fellowship course that begins in 2009, TA will be provided to incorporate HIV into the regular curriculum of the medical and nursing undergraduate and post-graduate courses, to expand research pertaining to infectious diseases such as HIV and TB and to establish a 'chair' for infectious diseases within the RGUHS.

The support to the NRHM and the SIHFW, the department of Health and Family Welfare will continue to receive need based TA for integration of HIV into induction training of government PHC staff.

ACTIVITY 4: Reduction of stigma and discrimination
Samastha will continue to reduce stigma in health care and community settings to ensure affected and vulnerable populations are not discriminated against and are able to access services. About 100 health care providers will be trained on-site using the modules developed by Engender Health. This training will saturate teams in CCC, ART centers and ICTC settings to reduce stigma and discrimination processes in the healthcare setting.

Village Health and Sanitation Committees (VHSCs), the focal point for reduction of stigma and discrimination in community settings, comprised of local leaders, opinion makers, and village-level government functionaries will continue to be strengthened through funds leveraged from NRHM.

ACTIVITY 5: Training and systems strengthening for grass-roots link workers
The link workers who are tasked to provide referrals for MARPs to HIV services will continue to be trained to equip them to be effective frontline workers. Pre-service training will cover about 100 link workers and 100 peer educators. Capacity of the identified training institutions for field level workers will

continue to be built.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	131,362	

Narrative:

Summary:
The NACP-3 prevention strategy includes reaching vulnerable youth at risk through the link workers and through outreach by existing cadres of governmental health programs. A key challenge in the selected districts of Karnataka where Samastha works is the practice of child marriage, which translates into early sexual activity in the age group of 15-17 years. The Samastha project has worked intensively in 12 districts to generate awareness and skills on abstinence and partner reduction/fidelity messages in the past three years. However, in FY10, the project aims to gradually transition out and reduce the direct interventions and move to TA to build capacity of existing health workers to address fidelity and faithfulness messages. The project will adopt a differential approach across districts through capacity building of a) the link workers in districts where HIV risk is higher and b) of existing government field level functionaries where the HIV risk is lower and more dispersed.

In FY10, Samastha will focus only on five high prevalence districts through the link workers (LW) and volunteers to reach the target population directly. In the remaining seven southern and central districts of Karnataka, the project will explore ways to build capacity of existing health and other village functionaries to reach the target group. This will include training of other cadres of health workers under the NRHM such as anganwadi (nutrition) workers (AWW) and Accredited Social Health Activists (ASHA) to build their capacity to incorporate HIV/STI related messages when working with young people.

The target group for this program area is male and female youth (15-24 years) in the general population in rural Karnataka. Behavioral assessments in early 2009 indicate that 11% of unmarried boys and 2 % of unmarried girls engaged in pre-marital sex. The project will continue to provide information on abstinence and fidelity to young boys and girls and men and women in 835 villages across five districts. About 20,000 individuals will be directly covered under this program area during the period. The prevention strategy will specifically address delaying sexual debut and reduction of concurrent sexual partnerships with emphasis on being faithful to a single partner for the target audience of married individuals in this age group. The interventions will continue to include gender sensitive group communication tools like 'Stepping Stones' which stimulates discussions on delaying sexual debut, develops skills to tackle sexual coercion and builds peer pressure to support HIV prevention related behaviors.

TA currently provided to NACO for the development of guidelines and expansion of the LW scheme

across the country will continue. Bagalkote district, a NACO recognized learning site for the LW scheme will continue to support other states and partners in conceptualizing and implementing the scheme. TA will also be provided to the NRHM and KSAPS to ensure that youth friendly services are integrated into the ICTC services.

ACTIVITIES AND EXPECTED RESULTS:

Activity 1 – Delaying sexual debut among young people
Among the young boys and girls (15-24years) the focus will be to delay sexual debut. 20,000 individuals will be reached through group sessions using Stepping Stones. This will continue to be conducted with groups of boys and girls to ensure that they understand their risks and vulnerabilities. These sessions also help the participants to reflect on their life situations and choices that they make. However the challenge in the rural areas has been to find unmarried young girls. Child marriage practices are still prevalent in the villages and the most affected group is the young girls. Hence along with working directly with girls and boys, it will be important to work with the community and family to support them in this process. Another advantage of the group process is the peer support.

Activity 2 – Increased focus on young and vulnerable girls and women at risk
The project will prioritize working with young girls in the devadasi (traditional temple sex workers) families, families headed by single women, families in debt or poverty and families from the scheduled caste community. About 1,000 girl children in such families will be provided with information on sexual health and skills to be assertive against violence and coercion. These girls will be specially tracked and followed up by the link workers to ensure links and access to education and health services. Livelihood security and strengthening their economic standards through links with rural development and economic programs in the villages will also be undertaken as part of sustainable programming. Community support for such families will be built through effective outreach and media activities such as folk theatre and traditional art.

Activity 3 – Enhancing sustainability through capacity building of existing functionaries in the village and volunteerism
In the southern districts of the project, the target group will be reached through the existing functionaries of the government and the project will provide TA for building their capacity. About 1,000 AWW and the ASHA of the village will be trained to work with young boys and girls specially addressing their risks and vulnerability with the objective of delaying sexual debut or supporting them to be faithful if they have a

partner. The trainings will be conducted in the village or in cluster of villages in consultation with the line departments. Additionally, the project will build a cadre of 1000 volunteers in the villages, who will undergo and complete Stepping Stones sessions before qualifying to become volunteers. The role of the village volunteers will include providing awareness and correct information and provide effective linkages for services to the young people.

Activity 4 - TA at the national and state level
The LW scheme is now being expanded across the country under the Global Fund initiative of NACO in all high priority districts. The project site at Bagalkote will function as an experiential residential on-the-job learning site for the LW scheme. Participants from government, NGO and stakeholders supported by NACO will learn to implement the operational guidelines for the LS scheme through this participatory training. Samastha will provide TA for the curriculum development of the nationwide induction training and the implementation of the strategic information systems. At the state level, AWW workers under the DWCD and ASHA workers under the NRHM will be taught to address risks and vulnerabilities of young people through the NRHM initiative.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	354,955	

Narrative:

Summary
The focus will be on most at risk populations (MARPs): female sex workers (FSW), their regular partners / lovers and high risk men and women in the rural areas of 12 districts of Karnataka (KN). In FY10, Samastha aims to reach 18,000 rural MARPs (including 12,000 female sex workers and at-risk women and 6,000 high-risk men). The rural mapping exercise in FY08-09 showed that most MSM are urban based and covered through the Bill and Melinda Gates Foundation (BMGF). Additionally, the mapping did not show significant intravenous drug user (IDU) populations in the rural areas targeted by under Samastha.

The objective of the COP intervention is to help the target group perceive their risks and vulnerabilities, access treatment for STI and gain skills to negotiate and use condoms during sexual acts. The strategies include involving the MARPs in a process of reflection so that they understand various life situations that put them at risk and feel empowered to make safe choices during those situations. The underlying principle is to address issue of gender inequity which put men and women at risk of diseases and empowers the target group to make safe choices. Hence building strong and supportive community structures in a non-discriminatory and supportive environment will continue to be a key strategy.

Additionally, the project will address transition as it enters the final year of implementation using a two-pronged approach of evidence-based prioritized interventions and leveraging through other programs including the national program. The evidence from two years of program implementation has shown that sexual networks that include both commercial as well as non-commercial networks exist in five Samastha districts and that seven districts have mainly commercial sexual networks. The program strategy has been refined in accordance with this evidence and a differential strategy has been adopted for the five northern KN versus the seven central and south Karnataka districts. Based on the refined strategy, the project will focus directly on all MARPS listed above in two of the five northern districts where the HIV prevalence is high. In three of the five northern KN districts, the FSW and partners coverage will be leveraged through the BMGF funded program. The other MARPs including clients of FSWs and high risk men and women in these three districts will continue to be reached by the Samastha project. In the remaining seven districts the project will reach sex workers and their regular partners only, but will strengthen the capacity of the existing government functionaries and services to promote condoms and other prevention among those with risk behavior in the general population.

This strategy of reaching the rural MARPs fills a critical programmatic gap area in the state of KN. The strategies and implementation models developed under Samastha have helped shape the national program strategy for reaching rural MARPs using the link worker (LW) scheme which is now rolled out by the national program in 180 high prevalence districts across the country. Link workers are village level workers that link prevention interventions with CT and care and support services. The Samastha project has provided TA to the national program in developing the operational guidelines and developing the MIS and M&E framework for this program.

In the last two years, the comprehensive prevention program under the project has been broad-based to include structural interventions like addressing violence, gender, community mobilization along with condom promotion and STI services. Increased focus will be placed on mobilization of MARPs to access CT services as well as to provide care and treatment services to those MARPs who are people living with HIV/AIDS (PLHIV), given the increasing evidence that ART can reduce the risk of sexual transmission. This "combination prevention" strategy will empower the MARPS to access better health and education services. As part of sustainability, community-based organizations of sex workers are also strengthened in organizational development and project management, while leveraging with Village Health and Sanitation Committees (VHSC) under the NRHM to support and sustain the behavior change process by creating an enabling environment.

Activity 1: Improving focus in outreach for MARPs
A) Peer education and condom promotion for improved focus on MARPs and their partners as part of combination prevention programming

The Samastha project in the southern districts will focus only on female sex workers and their partners as a main target group for condoms and other prevention through outreach. Peer sex workers will be supported by field level supervisors. However, given the dispersion of sex workers in the villages, each peer educator will be responsible for 35- 50 sex workers. A total of 8,000 sex workers will be reached directly through the Samastha intervention. Using the experiences gained from the pilot project on rural social marketing of condoms in FY08, the project will leverage support from PSI's NACO supported project to ensure social marketing condom outlets in 600 Samastha villages in addition to the 1,600 free condom outlets.
The project will also address structural issues in sex work like that of gender, power disparity among facilitators (brothel madams, pimps) and sex workers and will address issues related to crisis and violence that they face due to the inequity. The project will also facilitate a sense of self esteem and dignity among the sex workers through the process of building group solidarity.

B) Addressing issues of gender inequity and communication
The training package called Stepping Stones will continue to be used with at-risk men and women especially in the five northern districts to support the men and women to understand their risk situation and find practical solutions to make safe choices. Group sessions give a sense of solidarity among the members and also maintain peer support to practice safe behaviors. These group members will be also referred to prevention and care services as per their need and followed up to ensure quality service was available. About 4,000 women and 6,000 men at high risk of HIV will be reached through the Stepping Stones intervention. LW and their supervisors will be responsible for strengthening a community response through VHSCs.

C) Community-friendly monitoring tools for improved quality assurance in peer education
The project has devised community-friendly tools for monitoring the project that can be easily used by the outreach staff for monitoring their contacts. These tools not only help them in monitoring but also create a sense of ownership for the community that they are in charge of. Peer cards, peer calendars, village summary report and maps of targeted prioritized segments of MARPs to be reached will continue to be used as tools for tracking individuals and for monitoring progress. The community based monitoring tool facilitates the tracking of each member of a MARP registered with the project and validated by selected 'senior' sex workers who serve as volunteers in the monthly review meetings of peer educators.

D) Sustaining changes through involvement of existing community structures and volunteerism
Building an enabling environment is a prerequisite for any prevention strategy to succeed. The larger general community needs to support the prevention strategies and people practicing prevention. The project will continue to involve and strengthen the VHSC to take up the prevention and care related activities leveraging the funds allocated to them under the NRHM. The LW is part of the local community

and will serve as a trained resource pool in the village. Efforts will be made to advocate for compensation of the LW through the VHSC to continue their activities. In southern and central districts of KN, the capacity of 1,000 AWW and ASHA workers will be built integrating skills for risk assessment and interpersonal communication and also serve as a resource for free condoms.

Another strategy to build ownership is to expand on a volunteer base in the villages to ensure that people among MARPS and general population feel a sense of responsibility towards HIV prevention and care. The volunteers will support the LW in reaching out more widely.

Activity 2: Institutional capacity building of Community-Based Organizations (CBO)
It is expected that under the NRHM, the VHSC will eventually take responsibility for prevention and care of HIV among the general population. However, coverage of sex workers who are marginalized will continue to need additional support. The project will support FSW in rural KN to form support groups and link up with existing FSW CBO to strengthen their collective voice. Building group solidarity will not only provide them a space to share their pains and happiness but will also provide a space for advocacy for a life of dignity.

Activity 3: TA at the national and state level
The Samastha project will continue to guide and support the national LW scheme as an opportunity to halt rural HIV transmission. TA for development of operational guidelines, training of trainer programs, Bagalkote learning site and support for the implementation of the MIS and M&E framework of the LW scheme will continue.

At the state level, the project will continue to provide district level supportive supervision through its cadre of regional managers. Efforts will also be made to build capacity of the DAPCUs for the monitoring of combination prevention programs, links and also analysis of data. They will be trained to use triangulated data to determine district-level rural risk and transmission dynamics. Data from other studies will be documented and disseminated to increase understanding and estimation of the incidence and prevalence of HIV among rural sex workers on a regular basis.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	30,351	

Narrative:

SUMMARY
The Samastha project will continue to implement a modest PMTCT program with increasing focus on provision of TA for efficient delivery of quality PMTCT services.

Under the National AIDS Control Program – III (NACP-III), there has been a significant scale up in the number of CT sites throughout the country. Karnataka has more than 561 full-fledged CT sites of which 50 centers are in non-government settings under the public-private partnership initiative and 30 centers are mobile testing centers. It is also planned to launch CT services under the NRHM in at least 596 "24-hour" primary health care (PHC) centers by early 2010.

In FY08, Samastha provided TA to link PMTCT activities with the NRHM initiatives in KN. In FY09 CT services were configured to reach most PHC within the districts. DAPCU medical officers were trained on the convergence between the HIV and Health program and District RCH officers made accountable for ensuring hospital delivery and administration of ARV prophylaxis. As a result of this convergence, the coverage of CT services for the statewide annual estimate of 1.2 million pregnancies has increased from about 17% to more than 60%. The target is to reach an antenatal coverage level of more than 80% with CT services and administration of prophylaxis and other services in the cascade. Increased access by positive pregnant women to the state funded 'Yeshaswini' insurance scheme that incentivizes institutional deliveries, has helped increase PMTCT uptake by more than 3000 in FY09. However this is still about 50% of the known HIV- infected pregnant women. USG-supported Samastha project will aim to increase this figure through TA to the NRHM.

Despite the massive gains made in coverage of antenatal CT services and hospital delivery with ARV prophylaxis, challenges still remain such as:

• The scale up in ICTC and PMTCT has not been commensurate with quality in delivery of services.
• Procurement systems to ensure no stock-out situations of HIV test kits and Nevirapine are lacking.
• Expansion of PMTCT services beyond the CT and institutional delivery to also ensure counseling for safe infant feeding and follow-up of mother and baby is a need.
• Inadequate involvement of men in the PMTCT program and integration of family planning services.
• Diagnostic test for assessment of HIV infection in exposed infants is not available.

Samastha will continue to provide TA to the NRHM and KSAPS in this area. Included under this component are training programs for nurses and laboratory technicians in the 24-hour PHCs under NRHM to perform counseling and testing functions, TA for the roll-out of the integrated HIV-STI-PMTCT training package (ITP) for heath care providers in high HIV prevalence districts under the NRHM in collaboration with the SIHFW, ongoing capacity development of the DAPCU teams and TA to the IEC committee and technical cell for mobilizing pregnant women to access services. In response to SACS' expressed need for hands on training of counselors, two learning sites (LS) situated within the government recognized CT sites will continue to be supported. One will be in north Karnataka and the other in the south.

Engender Health will continue to work in close collaboration with the NRHM to integrate infection prevention and stigma and discrimination reduction in all health care settings and the roll out of the ITP module. St. John's Medical College and Kempegowda Institute of Medical Sciences (KIMS) and a site in north Karnataka demonstrate, through their learning sites, the linkage between PMTCT, adult and child care and treatment services and community initiatives.

The Logistic Management Information System (LMIS) to support procurement, distribution and projection of HIV test kit requirements, will continue to be implemented.

At the district level, district supervisors will receive periodic refresher training through the accredited training center at the National Institute of Mental Health and Neurosciences (NIMHANS). In FY10 issues related to family planning and sexual health for PLHIV will be addressed. The implementation of the HIV module within the training of the government supported Accredited Social Health Activists (ASHA) will be another area of focus.

In the five norther KN districts, Samastha link workers will directly mobilize pregnant women to access the full range of PMTCT services, including effective referrals to the ART and CCC services and follow-up of the child. In the remaining seven districts in south and central Karnataka, outreach workers will be placed at high-volume CT sites to provide post-test counseling follow up and linkage to care services for positive pregnant women. Additionally, government functionaries including the ASHA and community based outreach workers will be capacitated to make effective referrals for nutrition support.

ACTIVITIES AND EXPECTED RESULTS:

Activity 1: TA for improving efficiency and quality of PMTCT services
a) Development of model PMTCT LS
Two LS will be initiated in north and south KN. In collaboration with the Global Fund supported training institutions for nurses which provide pre-service training for developing cadres of nurses trained in HIV care and the training institutions developing cadres of counseling mentors, the USG-supported LSs will provide hands-on training and skills to complement their knowledge. These sites will aim at achieving all the quality and quantity indicators of an effective PMTCT program such as: follow-up of identified cases, monitoring administration of nevirapine for both mother and child, partner testing and linkages for early initiation of ARTs, ensuring adherence to drugs, safe infant feeding practices, immunizations, follow up of the mother and baby and HIV testing of the child at 18 months, and integration into RCH (reproductive and child health) services including FP services. Apart from the government provided personnel, the project will provide for a supervisor to ensure quality and mentoring.

b) Institutional capacity building for quality delivery of services
At the state level and regional level, District Supervisors are in place as part of the DAPCU in all 29 districts in KN. NIMHANS, a Samastha technical partner has leveraged NACO support for training and mentorship of the district supervisors across all states in south India. TA from the Samastha project will continue to be provided for the development of the training package of district supervisors. At the state level, Samastha will provide ongoing TA for supervision and monthly review meetings and quarterly regional reviews of the DAPCU teams. The Samastha project will continue to provide TA for the roll-out of the ITP module in high HIV prevalent districts while leveraging resources from the NRHM and SIHFW. This package will ensure that all health functionaries in these districts are trained to identify, manage, counsel and refer HIV positive pregnant women and her infant or child. The training of trainers (TOT) and the TA for monitoring the roll-out are supported by Samastha; the training itself is leveraged from the NRHM, through the State Institute of Health and Family Welfare (SIHFW). To make the CT sites friendly to beneficiaries, sensitization programs on stigma and discrimination will be conducted. The TOT programs will be conducted by Engender Health under the Samastha project and will be rolled out through the KSAPS appointed District Supervisors.

c) Quality assurance of lab services
Samastha will continue to work in close collaboration with NIMHANS; the nodal centre for the laboratory related quality assurance in HIV testing to adapt and disseminate the NACO recommended protocols and standard operating procedures (SOPs) and External Quality Assurance Scheme (EQAS).

d) Logistic Management Information System (LMIS)
Samastha project will continue to support the computerized LMIS that facilitates procurement management and distribution of pharmaceutical supplies across the state.

Activity 2: Demand Generation for increased uptake of PMTCT
Mobilization of pregnant women to government recognized ICTC sites will be facilitated though NGO outreach teams in the five districts that reach out through link workers under the Samastha project. In the remaining seven districts; FSW peer educators and local health functionaries such as the anganwadi worker (AWW) under the department of women and child development and the ASHA worker under the NRHM will be trained to make appropriate accompanied referrals to CT services. Samastha funds will be used to train newly recruited peer educators and link workers to identify and educate pregnant FSW to access CT and other HIV related services.

Activity 3: Facilitation of convergence activities to increase uptake
Link workers and peer outreach workers placed at CT sites to support post-test counseling will facilitate

linkage to ART and delivery services. The integration between the PMTCT and NRHM program has ensured that all HIV positive pregnant women have access to a hospital delivery and nevirapine prophylaxis as per the national protocol. Many of the community care centers (CCC) started under Samastha and transitioned to the Global Fund project have integrated CT and PMTCT services. Samastha will facilitate the roll out of combined HIV-STI-PMTCT training package across high HIV prevalence districts. TA will continue to be provided to the laboratories at St. John's and KIMS hospitals in Bangalore to leverage resources to enable them to undertake HIV DNA testing for diagnosis of HIV in infants. Samastha will continue to publish the newsletter circulated state-wide on counseling issues as a joint collaborative effort between the technical partner NIMHANS, KHPT and the state SACS which will inform all government and non-government organizations of the key initiatives, success stories and challenges in CT.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	25,000	

Narrative:

SUMMARY:
This activity is a continuation of initiatives under PEPFAR-funded Samastha project that commenced in 2006. No fresh funds will be added to this technical area in FY10 when only technical assistance (TA) will be provided to support the state efforts for TB-HIV management. The project provides quality HIV palliative care services in fifteen districts in Karnataka (KN) and five coastal districts of Andhra Pradesh (AP) with the TA of Engender Health. Activities are managed at the district level by University of Manitoba/Karnataka Health Promotion Trust (UM/KHPT) regional staff in KN and LEPRA society in AP, both of whom work closely with the state TB division, Revised National TB Control Program (RNTCP) consultants and district TB officers.

The activities are targeted to reach people living with HIV/AIDS (PLHIV) to be actively screened and treated for TB disease by establishing linkages and referral mechanisms with the RNTCP. The activity previously targeted those newly diagnosed with TB to perform a behavioral and clinical assessment in order to determine the need for referral for counseling and testing for HIV. More recently, Karnataka is one of the states identified for implementation of the Intensified TB program, wherein all PLHIV are screened for TB symptoms at every visit and all newly diagnosed TB patients are referred for HIV counseling and testing.

Some of the challenges that this program area continues to face include:
• The provider initiated counseling and testing of all newly diagnosed TB patients reported unexpectedly high levels of HIV-TB co-infection ranging from 13-56% among newly diagnosed TB patients.

• A simulated patient survey among general practitioners across the state showed that few practitioners refer TB suspects or patients to the RNTCP program, despite having adequate knowledge about the same.
• The number of newly diagnosed TB patients is about 55,000 per year. There are logistic and procurement challenges to ensure 100% coverage for counseling and testing for HIV.
• The laboratory based monitoring for liver function is inadequate for patients concurrently on anti-TB and ART medicines.
• Lack of nutrition interventions for co-infected patients poses another challenge.
• The Samastha project does not have any PEPFAR allocated funds for this area, except as a component of Health System Strengthening.

The RNTCP is a centrally sponsored national program that places a high emphasis on diagnosis and treatment of TB. Recent attempts have been made to ensure that Community Care Centers (CCC) and Integrated Positive Prevention and Care –Drop in Centers (IPPC-DIC) are integrated into the service network of the RNTCP and that counselors are placed at DMC to ensure effective HIV-TB linkages. The Global Fund funded CCCs are National AIDS Control Organization (NACO) supported inpatient facilities for minor opportunistic infection (OI) management and antiretroviral therapy (ART) adherence. The IPPC-DIC is centers run by networks of PLHIV providing both medical outpatient and social sector services for PLHIV and their families. Link workers have been trained to identify TB suspects and refer all suspects and PLHIV for TB screening. They have also been trained to refer all newly diagnosed TB patients for counseling and testing and to ensure compliance to TB treatment and adherence to ART.

Some of these initiatives and linkages have resulted in the significantly increased coverage of HIV counseling and testing (CT) among newly diagnosed TB patients from about 10% to more than 50% of the estimated 55,000 annual cases in the state.

ACTIVITIES:

Activity 1: TA at the state level

A) Consultant Support
The HIV-TB specialist under the Samastha project has been assigned fulltime to the Karnataka State AIDS Prevention Society (KSAPS) and will continue to provide ongoing TA. He has been instrumental in the roll-out of the intensified TB-HIV package across the state, in state level coordination planning and in the integration of TB-HIV services. He will continue to facilitate the SACS to implement Revised National Framework of TB-HIV collaborative activities and assist SACS and the district TB Officer (DTO) to develop District Action Plan on HIV-TB Coordination. Samastha will provide the TA for curriculum

development of the TB/HIV Intensified Package and assist the DTO in conducting Training of trainers (ToT) workshops for improved screening and treatment.

B) TA for operational assessments
TB is the leading cause of the death among PLHIV, especially among those admitted to the CCC. Many of the patients who have died were on treatment for both diseases. It is important to evaluate the reasons for treatment failure in this group. The project has planned for an evaluation and is leveraging this assessment through other resources. TA will be provided for the development of the protocol and to establish institutional partnerships for this study.

Activity 2: Increasing demand generation for activities that increase referral and links

A) Strengthening access to TB services for improved treatment adherence
CCCs previously supported under Samastha, now supported under the Global Fund care and support project are functional as DOTS centers (Directly Observed Treatment Short-course).

To strengthen TB-HIV integration, Samastha, with the lead of Engender Health worked with the Cardinal Gracious CCC and received sanction to pilot the location of a DMC (designated microscopy center) as well as DOTS at one site. Only six months since its inception, the CCC at Cardinal Gracious Hospital has seen a marked increase in the number of patients referred for TB testing and an increase in the percentage of patients diagnosed as having active TB. It is planned to replicate this initiative in other neighboring districts.

Samastha participated in the joint district level reviews conducted by teams composed of a WHO consultant, District TB Officer, state TB-HIV consultant (Samastha/KSAPS) and local medical regional managers (Samastha). In Karnataka there is no NGO implementing the Global Fund for AIDS, TB, and Malaria round four (GFATM) HIV-TB coordination activities. The follow up actions will continue to be facilitated and monitored by the Samastha staff.

B) Increasing TB diagnosis and treatment among PLHIV
Outreach staff of CCC and Integrated Positive Prevention and Care –Drop in Centers (IPPC-DIC) will continue to accompany PLHIV referrals for sputum testing and x-ray screening for those suspected to have TB. At least 12,000 adults and children living with HIV will be screened for TB and 1,200 will be followed up for complete treatment.

Outreach workers, link workers, PLHIV peer outreach workers, peer educators among sex workers and counselors will continue to promote utilization of TB diagnostic services among the communities where

they work. They were trained to identify potential TB disease, to make referrals to diagnostic and treatment services, and to follow up with patients to ensure compliance to treatment and linking them to ART centers for evaluation for initiation of ART. Samastha project staff in all the project districts will also continue to follow up with DTO and the DOTS providers to ensure that TB diagnosed patients are routinely screened for HIV and referred to CT sites for HIV screening which is usually co-located where DMC-TB diagnosis is carried out.

Engender Health and KHPT staff will continue to provide hands-on TA support to outreach and link workers, PLHIV peer educators to enhance the utilization of TB diagnostic services and increase the referrals to diagnostic and treatment services.

C) Improving healthcare providers' capacity to diagnose and treat TB
The 205 staff at the service outlets underwent TB-HIV training of two or three day's duration. Engender Health's HIV/TB specialist led the training for medical officers, counselors, and health workers. Engender Health provided technical support in capacity building and quality improvement. This support and training will continue for newly recruited staff as part of in-service training, but will be leveraged from state TB-HIV program.

Karnataka was the first state to roll out the training program for the intensified TB/HIV initiative. Almost all health care staff has been trained at the district level. At both the state and individual Samastha clinic levels, capacity-building and systems strengthening have resulted in intensified case finding. For the State of Karnataka, the roll-out of training and supervision show improvements against 2008 targets set for cross-referrals between the Revised National TB Control Program (RNTCP) and HIV counseling and testing center (ICTC).

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9249	**Mechanism Name: Sararth-FHI**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Family Health International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,377,954	
Funding Source	**Funding Amount**
GHCS (State)	209,954
GHCS (USAID)	1,168,000

Sub Partner Name(s)

Indian Network of Positive People	National AIDS Control Organization	Salaam Balak Trust
Women's Action Group, Chelsea		

Overview Narrative

The Samarth project is implemented by Family Health international (FHI) and contributes to implementation of quality HIV/AIDS prevention, care, and treatment through technical assistance (TA), capacity-building and institutional strengthening of government and civil society. The overall goal of Samarth is to improve the effectiveness of the response of government and civil society for evidence-based HIV policy and programs in India.

The project provides TA to the National AIDS Control Organization (NACO), the Global Fund, key government ministries, State AIDS Control Societies (SACS) in the USG priority states, USG partners and civil society organizations under the framework of the National AIDS Control Program III (NACP III). Samarth uses a variety of approaches for providing technical support including mentoring and training, influencing policy through collaborations and partnerships, sharing knowledge and good practices and strengthening data quality systems and placement of program and technical experts.

With the roll-out of NACP-III and increasing demand for TA, the project refocused its strategies to prioritize TA in areas of health system strengthening (HSS) including Human Resources for Health (HRH), orphans and vulnerable children (OVC) and strategic information (SI) to the national and state governments and other stakeholders. Samarth identifies program gaps and provides support in areas like development of the national operational guidelines for implementing OVC programs and national Greater Involvement of People Living with HIV/AIDS (GIPA) strategy, mentoring of technical staff at NACO and SACS; and mainstreaming HIV/AIDS into the Ministry of Women and Child Development (MWCD).

Samarth supports key personnel in NACO to provide national leadership and support to SACS and Distract AIDS Prevention Coordinating Units (DAPCUs) in responding to technical and programmatic needs related to implementation of NACP-III. At the government's request, Samarth supports the National

Technical Support Unit (NTSU) at NACO to provide TA in key technical areas. This includes support for key positions -Team Leader, National Epidemiologist and Monitoring and Evaluation (M&E) Specialist. The mentoring plan for NACO and SACS developed by Samarth has leveraged resources from various donors and built strategic partnerships for in-service training of technical and senior management officials in the key areas of program management, M&E and institutional strengthening.

NACP III does not have budgetary allocations for OVC, which have been included under the Round 6 of the Global Fund Project covering four high prevalence states. Samarth has been successful in advocating for a focus on OVC under NACP-III. This has resulted in development of the National Operational Guidelines for OVC in collaboration with the National OVC Task Force (TF) consisting of NACO, MWCD, USAID, UNICEF, International HIV/AIDS Alliance and Clinton Foundation.

Samarth's strategic guidance and support to the TSU to India's largest state of Uttar Pradesh (UPTSU), has facilitated the substantial scale up of prevention programs for most at risk populations (MARPs) and migrants in the state from 20 interventions to over 100 interventions. The project also provided support to UPSACS to streamline SI systems. Samarth is part of the national Technical Working group (TWG) on BSS and Sentinel Surveillance and provides regular guidance to the Strategic Information Management Unit (SIMU) in NACO.

Samarth works in close collaboration with the India Country Coordination Mechanism (CCM) Secretariat of the Global Fund and provided TA for development of the national proposal on HIV. It also supports regional and national consultations for greater engagement of the civil society and the private sector in the Global Fund projects. Following an interim arrangement of support for the India CCM, the Samarth Project has successfully submitted a proposal for mobilizing resources for the India CCM Secretariat from the Global Fund. Samarth has been a key player in mainstreaming HIV/AIDS in various government departments. In collaboration with UNICEF and UNIFEM, HIV/AIDS cell has been established to integrate HIV/AIDS activities into existing and future schemes of MWCD. Samarth was able to leverage resources for mainstreaming of HIV/AIDS into MWCD.

Samarth in partnership with the Indian Network for People Living with HIV/AIDS (INP+) provides guidance and leadership to People living with HIV/AIDS (PLHIV) at the national and state levels, influences national greater involvement of people living with HIV/AIDS (GIPA) policy, and strengthens the capacities of networks of PLHIV. Samarth also has two demonstration projects in Delhi which focus on community and home-based care (CHBC) for OVC and their families; and prevention of HIV among street and vulnerable youth and children. Samarth demonstration partners continue to leverage services such as nutrition, medicines, investigations, transportation for antiretroviral therapy (ART), hospital services, education, vocational training and household economic strengthening for OVC.

Samarth will establish mechanisms for sustainability of existing support to its stake-holders beyond the life of the project. An HSS assessment in early March of the various technical positions at NACO revealed a significant number of vacancies and duplication of federal-state human resources. Based on this feedback, the project facilitated a restructuring of various TA mechanisms at NACO, including that of the TSUs to optimize efficiency and scale up of programs. This includes decentralized mentoring assistance at the district level to provide hands-on TA and capacity building to local implementing partners. The project also advocated with NACO to revise the technical support assistance from various donors and led a consortium of donor partners to develop a common mentoring plan that will leverage donor-supported resources for optimal human resource utilization.

Samarth has mechanisms to address gender equity in its program. INP+ will ensure increased participation of women living with HIV (WLHA) into the network and in GIPA implementation. Samarth during implementation of the OVC program will emphasize access for young girls to HIV/AIDS care and treatment services, school education, linkages for income generation and vocational training activities. Samarth, through the gender consultant placed at the MWCD will advocate for improving WLHIV's access to various services through program and budget provisions in ministry work plans.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	13,500
Education	12,950
Food and Nutrition: Policy, Tools, and Service Delivery	12,600
Human Resources for Health	476,500
Water	3,150

Key Issues

Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Child Survival Activities

Budget Code Information

Mechanism ID:	**9249**		
Mechanism Name:	**Sararth-FHI**		
Prime Partner Name:	**Family Health International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	125,000	

Narrative:

SUMMARY

With USAID support (1999-2006), Family Health International (FHI) piloted child-focused demonstration models with 50,000 infected, affected, and vulnerable children in situations of low/high HIV prevalence, including children with/without parents, sex workers' children, children living on the street, children using substances, and children in rural, urban, and slum communities. With partners, FHI devised innovative strategies and tools: Life Skills Education (LSE) toolkit, protocol for child counseling on HIV, protocol for child detoxification and rehabilitation, and other communication materials. These initiatives informed national policy and programming: setting up of a national OVC Task Force (TF) with other stakeholders to bring issues to the forefront; developing National Operational Guidelines for orphans and vulnerable children (OVC) and prioritizing children and AIDS issues in the third phase of the $2.5 billion National AIDS Control Program (NACP-III).

Under the NACP-III, the long term goal is to achieve the highest quality of life for OVC which includes HIV-infected children and their families through delivery of a comprehensive package of care and support services.

Samarth with its mandate to provide technical assistance (TA) to the National AIDS Control Organization (NACO) program has identified the following strategic priorities in the area of OVC programming: contribute to USG strategic vision on OVC programming; develop the National Operational Guidelines for OVC in collaboration with the National OVC Task Force (TF) consisting of NACO, Ministry of Women and Child Development (MWCD), USAID, UNICEF, International HIV/AIDS Alliance, Clinton Foundation and FHI; Provide TA to NACO, SACS and USG partners to implement the National Operational Guidelines for OVC in collaboration with the National OVC TF; develop a resource base for tools for OVC programming; estimate HIV/AIDS orphans in India in collaboration with the National OVC TF; review the national OVC program in 2010 and influence NACO, allied ministries and the OVC task force members in future planning. These strategic priorities of Samarth cover all the top five PEPFAR priority actions on OVC.

Samarth addresses these areas through a two-pronged strategic approach: coordinated national action through the National OVC TF; and community-based demonstration project Chelsea in Delhi. The demonstration project also acts as community-based laboratory for Samarth to pilot innovative activities like LSE, Child Counseling on HIV/AIDS, Data Quality Assurance (DQA), Quality Assurance/Quality Improvement (QA/QI) and the Child Status Index. The learning from the pilots is used to influence the National Program and Policy for OVC. Samarth addresses the needs of children 0-17 years old, both male and female with increased focus on girls as traditionally girls have been neglected in terms of access to services, and are more prone to exploitation. The national activities of the project are for the entire country with a focus on high prevalence states and districts; the demonstration projects are in the slums of east Delhi and vulnerable neighborhoods of central and south Delhi. Samarth covers all the seven PEPFAR OVC services and the National Operational Guidelines on OVC also provide a framework for implementing all the seven services. The demonstration projects provide all services either directly or through referral and leveraging.

The Samarth project will continue to play a leadership role in the national TF and advocate for implementation of quality OVC programs. The Samarth project led the development of the first national operational guidelines for OVC programming and will provide TA to implement the national guidelines in select districts of the country. An OVC Trust was set up in select districts to provide financial support for health and educational needs of children. To support evidence-based programming for OVC in the absence of national data on OVC, the project facilitated a nation-wide exercise to estimate the numbers of OVC in the country using appropriate size estimation methods.

As a first step towards building health systems for convergence between NACP-III and other health systems involved in maternal-child health programs, the project facilitated the development of the HIV/AIDS cell in the MWCD and developed an annual work plan to mainstream HIV/AIDS activities. Similarly, as part of integration of child survival programs with HIV/AIDS, the project collaborated with the National Institute of Public Cooperation and Child Development (NIPCCD),the nodal training institute for staff implementing the government Integrated Child Development Services (ICDS) for revising their training curriculum to include HIV/AIDS prevention and care services.

The demonstration projects Chelsea implemented services for OVC and provided TA to other NGOs and government to design, implement and monitor OVC projects. Chelsea developed a training module on home-based care for OVC. The project influenced review and development of government policies and guidelines on child services. Samarth provided leadership to the national program on LSE and Child Counseling. A resource base was developed for tools for OVC programming. Samarth provided TA for leveraging services such as nutrition, education and household economic strengthening for children

infected and affected by HIV/AIDS. The development of the guidelines required coordination with a number of Government departments particularly NACO and MWCD.

In FY10, the following activities will be carried out:

ACTIVITY 1: TA to implement the national OVC program as per the Operational Guidelines
The National Operational Guidelines for OVC will be finalized based on the learning from the first phase implementation in the highest HIV prevalence districts. Samarth will provide technical support to NACO, SACS, and USG partners in scaling-up implementation of OVC programs in India. The MWCD will be supported in strengthening functioning of the HIV/AIDS cell, and mainstreaming the OVC services. Samarth will review the functioning of OVC Trusts set up in FY09; the findings will contribute to strengthening of the Trusts and setting up trusts in more districts. The resource base for OVC tools established in FY09 will be updated every six months. The good practices will be documented and disseminated nationally and in select states through workshops and other means. The geographical focus of the activity will be national and select states and districts. This activity will contribute to PEPFAR OVC strategic priorities "Strengthen systems/government/policy" and "Improving quality service delivery".

ACTIVITY 2: OVC Demonstration Program
Chelsea will implement services for OVC and provide TA to other NGOs and government to design, implement and monitor OVC projects. The geographical focus for delivery of OVC services will be Delhi and for TA it will be both Delhi and outside. Samarth will continue to provide mentoring and supportive supervision to build capacity of the partners in implementing high quality services to OVC and provide TA to different government and non-government agencies. Samarth will conduct three monthly program data audits and six monthly Quality Assurance/Quality Improvement audits. Samarth will also provide support for documentation and dissemination of good practices. Being the last year of Samarth, the support will be phased out in June 2011.

ACTIVITY 3: Wrap-around Support for OVC Programs
In FY10, Samarth will continue providing TA for leveraging services such as nutrition, medicines, investigations, travel to clinic/hospital, tuition fee, vocational training and household economic strengthening for children infected and affected by HIV/AIDS. The good practices will be documented and disseminated. The geographical focus of the activity will be national and select states and districts. Samarth will document the progress on leveraging on a quarterly basis. This activity will contribute to PEPFAR OVC strategic priorities "Community support and coordination" and "Family/household strengthening".

Indicator targets: The activities under this budget code will be monitored by the following output level

indicators.

o Number of eligible adults and children provided with a minimum of one care services;
o Number of HIV-positive adults and children receiving a minimum of one clinical service; and
o Number of eligible children who received food and/or other nutrition services.

In FY10, a total of 800 adult and 300 children will be reached through care services, 250 HIV infected adults and 150 children will be reached through clinical services and 150 infected children will be reached though food and nutrition services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	75,000	

Narrative:

SUMMARY

With USAID support (1999-2006), Family Health International (FHI) piloted child-focused demonstration models with 50,000 infected, affected, and vulnerable children in situations of low/high HIV prevalence, including children with/without parents, sex workers' children, children living on street, children using substances, and children in rural, urban, and slum communities. Realizing the need for strengthening the quality of child counseling and testing (CT) services, FHI along with the experience of its partners and in consultation with experts from different agencies including National AIDS Control Organization (NACO) and Ministry of Women and Child Development (MWCD) developed "Protocol for child counseling on HIV testing, disclosure and support". The document was published after review by the National OVC Task Force (TF) comprising the MWCD, UNICEF, USAID, International HIV/AIDS Alliance and Clinton Foundation.

Samarth with its mandate to provide technical assistance to NACO program has identified the following strategic priorities in the area of CT: influence the strengthening of the National CT Protocol, particularly for children; provide technical assistance (TA) in roll-out of training for counselors in the National Program; develop quality standards for CT; enhance capacity of Samarth Demonstration Projects in Child counseling; provide on-site child counseling training to counselors from government and non-government agencies. Samarth addresses these areas through a two pronged strategic approach: coordinated national action through the TF and community-based demonstration projects in Delhi (Chelsea, Salaam Baalak Trust (SBT). The demonstration projects also act as community-based laboratories for Samarth to pilot innovative activities like Child Counseling on HIV/AIDS and Quality Assurance. The learning from the pilots is used to influence the National Protocol and Program on CT. Samarth addresses the needs of

children 0-17 years old, both male and female with increased focus on girls who have traditionally been neglected in terms of access to services; they are also more prone to exploitation). The national activities of the project are for the entire country with focus on high prevalence states and districts; the demonstration projects are in slums of east Delhi and vulnerable areas of central and south Delhi.

Samarth invests modestly in CT only as part of demonstration models to government and nongovernmental organization (NGO) stakeholders to showcase quality CT delivery of services including a focus on data quality and on the full spectrum of CT services. Since FY10 will be the last year of the Project, the major activity will be to transition out and ensure Delhi State AIDS Control Society (SACS) is equipped to take over the community-based child counseling and testing service for OVC. The demonstration projects have implemented child counseling in line with the FHI protocol and have developed strong referral linkages with the government integrated counseling and testing centers (ICTCs). They have developed and practiced the quality assurance system for community-based CT. The pioneering work has drawn a number of visitors to the projects and interns have been placed by the National Institute of Public Cooperation and Child Development (NIPCCD) to develop skills on child counseling. Staff from the demonstration projects has been invited as trainers by different agencies.

In FY09, FHI provided TA to NACO in adaptation of the Regional Training Module on Counseling (developed by FHI Headquarters, UNICEF and WHO). FHI in collaboration with the National Task Force on Children Affected by HIV/AIDS (CABA) identified and trained master trainers on Child Counseling in the country. Chelsea and SBT projects provided hands-on skill building training to counselors. The most important challenge Samarth has experienced is influencing a revision of the national CT protocol to provide a comprehensive framework for dealing with different issues related to child counseling for testing, disclosure and support.

In FY10, the following activities will be carried out:

ACTIVITY 1: Transition of model sites that showcase delivery of high quality CT services

As part of the transition, Samarth will make adequate arrangements to phase-out Chelsea and Salaam Baalak Trust (SBT) projects. The local state government has evinced an interest in continuing with the community-based child counseling and testing service initiated by the demonstration projects. Chelsea and Salaam Baalak Trust (SBT) will provide TA to Delhi State AIDS Control Society (DSACS), local government health facilities and other NGOs to implement and monitor child counseling. The projects will conduct child counseling trainings and provide hands-on skill building training to counselors. The geographical focus of the activity will be Delhi. FHI will continue to provide mentoring and supportive supervision to build capacity of the partners in implementing high quality CT services to OVC and provide

TA to different Government and non-government agencies. FHI will conduct three-monthly program data audits and six-monthly Quality Assurance/Quality Improvement audits. FHI will also provide support in documentation and dissemination of good practices.

ACTIVITY 2: Institutional capacity building at national and state level to improve depth and scale of CT services
Samarth supports staff for oversight of the 4,000 plus CT centers scaled-up under the NACP-III. The project will work closely to ensure the quality delivery of CT services and operational guidelines to expand CT services to the round-the-clock primary health care centers currently operational under the National Rural Health Mission (NRHM). TA will also be provided to NACO and SACS in development and/or adaptation of technical standard operating procedures (SOPs) and development of a quality assurance (QA)/quality improvement (QI) framework. Good practices in counseling will be documented and disseminated.

ACTIVITY 3: Wrap-around Support for CT Programs
Samarth will continue to support Chelsea to implement CT activities for the most-at-risk children, youth and most at risk populations (MARPs) in the local communities. The demonstration project will leverage HIV test kits and human resources from the DSACS for organizing the community "Know your Status" camps.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	45,000	

Narrative:

SUMMARY

Under the National AIDS Control Program III (NACP-III), the long term goal is to achieve the highest quality of life for HIV infected children and their families through delivery of a comprehensive package of care and support services.

Samarth with its mandate to provide technical assistance (TA) to the National AIDS Control Organization (NACO) has identified the following priorities for pediatric care and support: contribute to USAID strategic vision on programming for HIV infected children; develop the National Operational Guidelines for care and support of HIV infected children in collaboration with the National OVC Task Force (TF) consisting of NACO, Ministry of Women and Child Development (MWCD), USAID, UNICEF, International HIV/AIDS Alliance, Clinton Foundation and FHI; provide TA to NACO, State AIDS Control Society (SACS) and USG partners to implement the National Operational Guidelines; develop a resource base for tools for pediatric

care and support programming; and estimate HIV-infected children in India in collaboration with the National OVC TF. Samarth addresses these areas through a two-pronged strategic approach: coordinated national action through the National OVC TF and Family Health International (FHI) sub-partner Christian Medical Association of India (CMAI); and support for a community-based demonstration project, Chelsea in Delhi.

CMAI has conducted training programs for various stakeholders, including health care providers in the private medical sector (missionary hospital settings). CMAI supported development of strong HIV care and support services for HIV-infected children within their member hospitals, with special focus on four hospitals, one in each of the USG priority states of Maharashtra, Karnataka, Tamil Nadu and Andhra Pradesh. CMAI also previously provided support to scale-up quality care for HIV-infected children through facility- and home-based care. However, the project was phased out in FY09 due to changes in the strategic priorities of Samarth.

The demonstration project Chelsea operates four clinics including three community clinics in the slums and one at a drop-in-center. The Medical Officer visits the clinics once a week to provide consultation on general health ailments and management of opportunistic infections (OI) to HIV infected children. Referrals are made to government hospitals for specialized consultation and hospitalization. The project also acts as a community-based laboratory for Samarth to pilot innovative activities such as Life Skills Education (LSE), Child Counseling on HIV/AIDS, Data Quality Assurance (DQA), Quality Assurance/Quality Improvement (QA/QI) and the Child Status Index. The learning from the pilots is used influence the National Program and Policy for HIV-infected children. Samarth addresses the needs of children 0-17 years old, both male and female with increased focus on girls traditionally have been neglected in terms of access to services. The national activities of the project focus on high prevalence states and districts; the demonstration project is in the slums of East Delhi. The demonstration project provides services to HIV-infected children either directly or through referral and leveraging

The demonstration project Chelsea implemented care and support services for HIV-infected children and provided TA to other nongovernmental organizations (NGOs) and the Government of India to design, implement and monitor projects on HIV infected children. Chelsea developed a training module on home-based care for HIV infected children. Samarth provided leadership to the national program on LSE and child counseling for HIV-infected children.

In FY10, the following activities will be carried out:

ACTIVITY 1: Support to Demonstration Program on HIV-infected Children
Chelsea will implement services for HIV-infected children and provide TA to other NGOs and government

to design, implement and monitor projects for HIV-infected children. Chelsea will continue to monitor the progress of quality of life of HIV-infected children through Child Status Index. The geographical focus for delivery of the services will be Delhi and for TA it will be both Delhi and outside. FHI will continue to provide mentoring and supportive supervision to build capacity of the partners in implementing high quality services to HIV-infected children and provide TA to different government and nongovernment agencies. FHI will conduct three monthly program data audits and six monthly Quality Assurance/Quality Improvement audits. The Quality Improvement initiative on improvement of nutritional status of children on antiretroviral therapy (ART) in Chelsea will be completed and the learning disseminated. FHI will also provide need-based support in documentation and dissemination of good practices. Being the last year of Samarth, the support will be phased out in June 2011.

ACTIVITY 2: TA to NACO, SACS and USG Partners for program with HIV- infected children
Samarth will provide technical support to NACO, SACS, and USG partners to scale-up implementation of care and support programs for HIV-infected children in India. The MWCD will be supported in strengthening functioning of the HIV/AIDS cell, and mainstreaming the services for HIV-infected children. Samarth will continue to provide TA to government and nongovernment organizations in implementing LSE and child counseling on HIV/AIDS. The good practices will be documented and disseminated nationally and in select states through workshops and other means. The geographical focus of the activity will be national and select states and districts.

ACTIVITY 3: Wrap-around support for HIV-infected children programs
In FY10, Samarth will continue providing TA for leveraging services such as nutrition, medicines, investigations, and travel to clinic/hospital, tuition fee, vocational training and household economic strengthening for HIV infected children. The good practices will be documented and disseminated. The geographical focus of the activity will be national and select states and districts. FHI will document the progress on leveraging on a quarterly basis.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	215,000	

Narrative:

SUMMARY

Strategic Information (SI) is considered a priority under the National HIV/AIDS Control Program III(NACP-III). In order to have a robust strategic information and management system, Strategic Information Management Units (SIMUs) were established at both at national and state levels to monitor strategic planning, monitoring and evaluation, surveillance and research activities. Samarth's SI program area will

focus on providing technical assistance (TA) at national, state, and district levels to strengthen data collection, analysis and its use for program planning.

Samarth as part of the national technical working group on estimation contributed to strengthening systems for national HIV surveillance and national estimates in close collaboration with the National AIDS Control Organization (NACO), National Institute of Medical Statistics, National Institute of Health and Family Welfare, Center for Disease Control (CDC), UNAIDS and World Health Organization (WHO). Samarth provided training and ongoing mentoring support to state level epidemiologists to strengthen state HIV surveillance systems, program data collection and analysis and monitoring and supervision of data quality. Samarth also developed and implemented a monitoring and evaluation (M&E) mentoring plan in coordination with other development partners to improve data management system, quality of the monitoring data and data usage.

In line with NACP-III goal to saturate coverage of targeted intervention programs, Samarth supported mapping of most at risk populations (MARPs) in all 71 districts of Uttar Pradesh. Samarth provided technical support to NACO and Uttar Pradesh State AIDS Control Society (UPSACS) to conduct a mid-term review of the national program and conducted behavioral surveillance survey (BSS) in the state of UP. As a part of strategic support to UPSACS, the project also coordinated data triangulation exercise to understand the HIV epidemic profile and developed district-level action plans to feed into the overall strategic action plan for the state.

Samarth conducted workshops for the USG partners on abstract writing and monitoring and implementation of quality interventions for orphans and vulnerable children (OVC) based on the needs expressed through a technical need assessment workshop. The project also contributed to integrating PEPFAR indicators into the existing reporting systems and collecting and reporting gender-disaggregated information on key indicators. Technical support was provided to USG partners for ensuring data quality and data accuracy through sharing best practices in data collection and management developed under Samarth.

In FY10, following activities will be conducted under the Strategic Information program area.

ACTIVITY 1: TA to NACO and State AIDS Control Societies (SACS) on improving M&E and the National HIV Surveillance System

Samarth will continue to provide mentoring support to the epidemiologists at the national and state level

in strengthening state HIV surveillance systems, monitoring and supervision of data quality, analyzing data from computerized management information system (CMIS) and conducting focused operation research and targeted evaluations. These epidemiologists will also contribute to analysis of epidemiological scenarios at the state and district level, identifying gaps in the existing intervention strategies and helping SACS to prepare strategic plans to address those issues. In addition, Samarth will share tools for assessing data management system including data quality and service quality standards and build the capacities of the M&E officers at the state level to implement those tools for monitoring data quality at collection, collation and reporting level and in the use of data for programming. Samarth will conduct trainings at the national and state level on the use of various models of data triangulation to track the epidemiological trends and using the findings to develop implementation strategies and designing new intervention programs.

ACTIVITY 2: TA to NACO to improve functioning of Strategic Information and Management Unit (SIMU)

Samarth will continue supporting the position of National Strategic Information Management Systems Specialist at the National Technical Support Unit (NTSU). Through this position Samarth will facilitate and coordinate with the national level M&E group and other development partners to establish an M&E framework in the spirit of the "Three ones"; review and modify indicators in line with national needs and standardized for global comparison; supervise and monitor the functions of state-level SIMUs; and provide technical inputs to the Evaluation and Operation Research Unit by analyzing programmatic data. In addition, Samarth will assess the needs of the state level SIMUs and will develop training modules in consultation with NACO and provide trainings to build the capacities of the SIMU team members for effective functioning of the unit. In addition, Samarth will provide support to documentation of best practices of the SIMU and will share with other SIMUs.

ACTIVITY 3: TA to NACO on improving the Computerized Management and Information System (CMIS)

Samarth will continue supporting the M&E Specialist at national level and provide trainings at the national and state level. The specific activities envisaged in FY10 includes upgrading existing CMIS to accommodate process-level indicators based on the national priorities; incorporate the provision of technical, logistics, and financial program monitoring; standardize existing reporting formats for each program area; facilitate implementation of SMART cards for ART patients; facilitate the process of digitizing HIV service centers across the country by type up to sub-district level; and facilitate GIS mapping of hotspots for MARPs. Through this position, Samarth will facilitate training of the state and district level data entry operators to increase reporting rates. In addition Samarth will review the existing system of data validation and consistency checks and will incorporate provisions for generating reports to ensure quality of the reporting data and taking corrective measures

ACTIVITY 4: TA to UPSACS on improving quality of prevention programs for MARPs
Samarth will continue support to UPSACS and provide TA through the UP Technical Support Unit (UPTSU). Samarth will share service quality assessment tools and train identified staff members form UPSACS and TSU to implement those tools for assessing quality of the prevention programs for MARPs and migrants in the state. Samarth will also contribute to developing action plans based on the quality assessment findings. Samarth will provide technical inputs to UPTSU to monitor the quality of the reporting data submitted by targeted interventions (TI) and support for preparation of a plan to improve the data management and usage of monitoring data for evidence based planning. In FY10 the project will also provide specific support to UPSACS for designing and implementing an evaluation plan for TI program and triangulate evaluation findings with other data sources to measure the effectiveness of these interventions at the state.

ACTIVITY 5: Mentoring support to NACO for M&E

Samarth has been providing mentoring support for M&E to NACO in collaboration with other development partners. In FY10, the Samarth project will coordinate with the identified state-level mentors and regional research institutes to identify further capacity building needs at the state and district level. Based on the needs assessment, Samarth will facilitate development of training curricula, prepare plan and execute mentoring support. In addition Samarth will also facilitate different trainings in collaboration with other development partners and will assess the effectiveness of the mentoring support.

ACTIVITY 6: Knowledge sharing with stakeholders

Samarth will document the unique experiences as a TA provider in strengthening the health systems at the national, state and district levels through adoption of different approaches, strategic collaborations and leveraging with other donors and partners. These lessons learned will be widely disseminated through a national level workshop.

In FY10, a total of 10 organizations and 90 individuals will be reached under this budget code area.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	809,954	

Narrative:

SUMMARY

Samarth has been supporting the National AIDS Control Organization (NACO) since 2006 in implementing the National AIDS Control Program Phase III (NACP III). It has succeeded in establishing its place as a technical assistance (TA) and capacity building (CB) support project at the national, state and district levels. Health systems strengthening (HSS) is a major focus area for NACP III and is also a major priority area for Samarth.

Samarth has been able to provide valuable contributions towards strengthening health systems. Samarth provided support to NACO, State AIDS Control Societies (SACS), USG partners and civil society in building capacities of government and civil society for effective management of HIV/AIDS programs and its quality, improved strategic information and built bold leadership and visibility of the USG-supported program. During the past three years, Samarth adopted different approaches in providing TA for HSS at the national, state, and district levels to improve the effectiveness of the response of government and civil society for evidence-based HIV policy and programs in India.

Under leadership and governance, TA provided includes; development of national operational guidelines for OVC; trainings and mentoring support to key staff of NACO and SACS including technical and program officers, M&E and F&A staff and SACS project directors as part of the approved national mentoring plan as a long-term strategy to build human resources for health at NACO and SACS; support to Uttar Pradesh Technical Support Unit (UPTSU) for providing technical support to Uttar Pradesh State AIDS Control Society (UPSACS) for strengthening the State-level Targeted Intervention Program; support to national and state HIV program for implementation of Greater Involvement of People Living with HIV/AIDS (GIPA) policy and building capacities of state-level positive people networks for supporting GIPA in their respective states in collaboration with UNIFEM and UNICEF to establish an HIV/AIDS cell at the Ministry of Women and Child Development (MWCD) for enhancing support for women and children affected by HIV/AIDS in policy and program areas, with special focus on gender issues and child nutrition; building capacity of UPSACS and TSU on project management and TIs and support for selection of new State Technical Resource Center for trainings of TI staff; continuing support to Global Fund Country Coordinating Mechanism (CCM) to strengthen the Secretariat in India by facilitating the enhanced role of private sector and wider civil society participation and support for proposal development.

As part of HSS the Samarth project has placed technical advisors and consultants at NACO in key technical areas of counseling and testing (CT), PMTCT, ART, Surveillance and monitoring and evaluation (M&E) including at the NTSU; as well as capacity building of health care providers across all 71 districts of UP on stigma and discrimination and of civil society and NGO partners in PEPFAR priority areas.
The Samarth project invests substantially in building state and national level information systems through its membership at the national TWG on behavioral surveillance survey (BSS) and Sentinel Surveillance

and also provides regular guidance to the SIMU at NACO. Samarth contributed to the mid-term review (MTR) of NACP-III through mapping, behavioral surveillance surveys and data triangulation in Uttar Pradesh. The project provided support to UPSACS to streamline the strategic information systems and the evidence generated strengthened the strategic planning process and the Annual Action Plans. As Samarth enters its last year, it will focus HSS investments on documentation of good practices in provision of TA at the national and state level.

ACTIVITY 1: Institutional capacity building at national level

Samarth will continue with support for institutional strengthening of NACO and ensure its sustainability by supporting the national technical support unit (NTSU) and key technical positions. In the first six months of FY10, Samarth will facilitate an in-depth assessment of human resources requirement at NACO in terms of revision of job descriptions, revision of the organogram and analysis of work-load of technical officers.

In continuation to the mentoring support provided in past years, Samarth along with the other development organizations will facilitate the design of long-term sustainable capacity building system for NACO staff to continue providing cutting edge leadership to the National Program beyond the Samarth project period. The facilitation will also explore possibilities for consolidation of donor support for training and mentoring including involvement of external experts and institutions as mentors.

Based on the revised national operational guidelines on orphans and vulnerable children (OVC) for the nationwide pilot, Samarth will provide technical support to NACO, SACS, and USG partners in scale-up implementation of OVC programs in India.

Samarth will continue to be part of the technical working groups for BSS, M&E and Sentinel Surveillance System. The Project will provide support to NACO for the strengthening of the strategic information management unit (SIMU); facilitate and coordinate with national level M&E group and other development partners to establish M&E framework in the spirit of "Three ones"; review and modify indicators in line with national needs and standardized for global comparison.

ACTIVITY 2: TA to build capacity at state and district level

The project supports the TSU in UP and will work on developing milestones to highlight transition of skills of TSU to the local SACS. The skills include project management, financial management, HRH and evidence based planning. During the three years of support to TSU, Samarth has been able to streamline management, quality, strategic information generation, supportive monitoring and evaluation and

documentation which will be handed over to SACS during the transition phase. The strategies for smooth transition and take-over by SACS will include hands-on TA support, consultant support for short term if necessary, trouble-shooting, developing guidelines and facilitating effective linkages with the State Training Resource Center.

Samarth will continue to provide cross learning between USG Supported SACS by engaging experts from other states for trainings and learning visits.

ACTIVITY 3: TA for mainstreaming HIV/AIDS into other Government of India ministries

This is an intentional spillover activity which leverages the work done by other national health programs that address maternal and child health and reproductive health. Hence, Samarth will continue to collaborate with MWCD in addressing gender issues particularly women living with HIV and OVC.

Samarth, jointly with UNIFEM and UNICEF, has led the mainstreaming of HIV/AIDS into the MWCD and has facilitated the establishment of the HIV/AIDS cell. Samarth will continue the support of the HIV/AIDS cell and mainstreaming services for women and OVC and the implementation of the operational plans. Samarth along with the partners will transition on ensuring enhanced collaboration between MWCD and NACO and establishing mechanisms for addressing HIV/AIDS issues into their regular programming. The efforts will be documented and shared with other ministries and NACO as models of replication and establishing linkages between them.

ACTIVITY 4: Strengthening the Secretariat of the India CCM of the Global Fund

As part of its transition, Samarth has successfully mobilized Global Fund support to the local Secretariat including support to fulltime staff. In FY10, Samarth's support to the CCM will focus on TA to develop the Global Fund national strategic application and also support the various regional consultations for proposal development. The project will work in close collaboration with NACO and the various principal recipients to strengthening monitoring and evaluation of the various Global Fund supported programs under Rounds 2,4,6 and 7 Samarth will also work with Global Fund to enhance civil society participation in the program, including orientation of new members of the CCM. Samarth along with other donors will support CCM towards greater participation of the private sector in submission of joint proposals with government and civil society to Global Fund.

ACTIVITY 5: Institutional capacity building of civil society

The two demonstration projects, Chelsea and Salaam Baalak Trust will continue to provide on-site

training and mentoring to local nongovernmental organizations (NGOs) and community-based organizations (CBOs) on OVC program and working with street children. Samarth will share with NACO and SACS the achievements from the two demonstration projects on: the community-based approach to providing services to HIV/AIDS infected and affected children and prevention of HIV among street children; the Life Skills Education (LSE); Child counseling; Quality Assurance and Quality Improvement Systems including the Standard Operating Procedures (SOPs) and Checklists; child status index for assessing quality of life of children; the Quality Improvement initiative for improving nutritional status of HIV infected children; data quality assurance (DQA) system; the training modules on OVC and HIV prevention and other implementation tools. Samarth will further strengthen the capacity of the demonstration projects in providing TA to Delhi SACS and NGOs. This will enable them to access increased resources from government and other sources and continue to serve as learning sites.

The institutional review of Indian Association of People Living with HIV/AIDS (INP+) conducted in FY09 to identify gaps in their institutional systems and assess their performance has highlighted the positive impact of building positive networks at district and sub-district level and enhanced linkages with prevention programs. INP+ will provide guidance at national and state level for implementation of GIPA policy and support State networks for providing support to SACS. INP+'s national and state level women's forums will be leveraged to ensure gender equity. This will include strategies and activities towards implementation of GIPA with enhanced participation of women living with HIV/AIDS, ensuring women's issues are addressed in policies and providing support for increased access to services. As GIPA policy would have been finalized by NACO and implemented by SACS during FY09, INP+ would provide supportive monitoring to SACS and NACO for comprehensive coverage. INP+ with its state level networks will continue to provide support on GIPA and positive prevention as required beyond Samarth.

In FY10, a total of 120 organizations and 500 individuals will be provided training under this budget code area.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	108,000	

Narrative:

SUMMARY

Samarth, with its mandate to provide technical assistance (TA) to the national HIV/AIDS program is working on a model for HIV prevention among street children through promotion of risk avoidance behaviors: practice of abstinence; and promotion of secondary abstinence for sexually active children, mutual faithfulness and partner reduction among sexually active children. Samarth demonstration project

Salaam Baalak Trust (SBT) acts as community-based laboratory to pilot innovative activities, and serves as a site for training other non-government and government personnel. SBT addresses the needs of children 0-17 years old, both male and female with increased focus on coverage of girls who are more prone to sexual abuse and have less access to supportive services. The project takes special care to prevent sexual abuse of children below 10 years; risk avoidance is promoted among 10-17 years old children. The national activities of the project are for the entire country with focus on high prevalence states and districts; the demonstration project has an outreach on railway platforms and vulnerable streets of central and south Delhi.

The focus in the last year of Samarth will be to transition out of the intervention and provide TA to government and nongovernmental organizations (NGOs) in promoting HIV risk avoidance behavior among vulnerable children. SBT has developed a training module on "HIV related institutional capacity building, stigma and discrimination and community mobilization on HIV prevention services to street children". The work has drawn a number of visitors to the projects and interns have been placed by National Institute of Public Cooperation and Child Development (NIPCCD) to develop skills on promoting HIV risk avoidance behavior. Staff from the demonstration project has been invited as trainers by different agencies. SBT has a number of case studies to demonstrate the successful maintenance of HIV risk avoidance behavior; however, bringing street children back to abstinence (secondary abstinence) has been quite challenging. SBT will further strengthen its peer education, counseling and communication package to promote secondary abstinence.

In FY10, the following activities will be carried out:

ACTIVITY 1: Develop model of quality delivery of services for addressing vulnerable populations
Samarth will continue supporting SBT to develop best practices in HIV risk avoidance behaviors among street children in Delhi. The street children are mostly without their parents/guardians, runaway from their homes. On the street they are exposed to substance use and sexual abuse; the older children often abuse the younger ones. The outreach activities include mobilizing the children to attend non-formal education, life skills education and skills development to promote livelihood security. The activities prevent children from engaging in high-risk behaviors. FHI will conduct three monthly program data audit and six monthly Quality Assurance/Quality Improvement audits. FHI will also provide support in documentation and dissemination of the good practices. Being the last year of Samarth, the support will be phased out in June 2011.

ACTIVITY 2: Advocacy with government to include quality prevention programming in interventions mainstreamed for vulnerable populations
As part of the HIV/AIDS cell at the Ministry of Women and Child Development (MWCD) and National

AIDS Control Organization (NACO), the project will continue to advocate for the life skills education (LSE) program promoting HIV risk avoidance behavior among children. Samarth will provide technical assistance (TA) in implementing LSE activities through the MWCD and NACO. SBT will provide hands-on skill building training on AB prevention through LSE and other activities to different government and non-government agencies. The geographical focus for delivery of the TA will be both Delhi and outside. FHI will continue to provide mentoring and supportive supervision to build capacity of the partner to provide TA.

Indicator targets: The activities under this budget code area will be monitored by the following output level indicators.

o Number of the targeted population reached with individual and/or small group level preventive interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required;
o Number of community health volunteers who successfully completed in-service training program.

In FY10, a total of 850 adult and children above 10 years will be reached through A and/or B prevention messages and 45 outreach workers will be trained on providing prevention messages through community outreach services.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9254	**Mechanism Name: MASBOOT BANDHAN-Children in Need Institute (CINI)**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Children in Need Institute	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Child in Need Institute (CINI) along with Jharkhand State AIDS Control Society (JSACS) is working together towards stabilization of HIV in the state of Jharkhand. It has been designated as a low prevalence state, however highly vulnerable. "The HIV epidemic in Jharkhand is mainly driven by various vulnerability factors like out-migration, illiteracy and poor economic status." (JSACS Action Plan 2009-2010). The presence of most at risk populations (MARPs) especially female sex workers (FSWs) contributes to increased transmission of HIV. Making AIDS Services Stronger by Organizational Outreach through Training (MASBOOT) BANDHAN, is an initiative that seeks to understand and prevent HIV transmission through targeted interventions (TI) with FSWs in the three districts of Jharkhand.

The project is implemented in accordance with the National AIDS Control Program III (NACP III) Operational Guidelines. The TI uses a multipronged approach to bringing about behavior change amongst FSWs: building capacity of doctors to treat sexually transmitted infections (STIs), facilitating creation of supportive environment through sensitization of key stakeholders, and addressing events of crisis encountered by FSWs.

Geographic coverage:

CINI is operating in the three districts in partnership with three local NGOs: Ranchi –Srijan Foundation, Hazaribag –Rama Krishna Sharada Mission, and Dhanbad –Gramin Prodyogik Vikas Sansthan. The partner organizations are responsible for the direct implementation of the project whereas CINI provides technical assistance (TA), capacity building, supportive supervision and coordination.
The three districts are unique in their context and therefore reflect three different approaches to three different settings of sex work. However, the highly mobile nature of sex workers characterizes all the three districts.

Key Activities:
• Behavior change communication through promotion of safe sex through condom usage.
• Effective and efficient provision of healthcare for FSW.
• Creation of responsive systems for a supportive environment.
• Providing technical, managerial and operational support to the three partner organizations.

Strategy adopted for Health System Strengthening (HSS):

CINI implements its TI components in accordance with NACP III guidelines. The project is peer-led by the FSWs, many of whom have not disclosed their profession to their families and work in secrecy.

CINI refers FSW to government led integrated counseling and testing centers (ICTCs) for HIV testing. It provides TA to Jharkhand State AIDS Control Society (JSACS) on sensitizing and capacity building of frontline health workers, such as the auxiliary nurse midwives (ANMs). With respect to STI management, private practicing doctors have been identified and trained to provide the necessary services in lieu of a small service fee.

The year October 2009 – September 2010 is the transition phase hence the strategy for this year would focus on:
• A: Strengthening multi-sectional linkages for continuum of health care for FSW
• Capacity building of partner organizations on project management will form a key aspect to enable them to leverage funds for its operation on HIV.
• Formation and development of self help groups (SHG) of FSWs.

• B: Advocating for appropriate strategies for HIV prevention interventions with FSWs in Jharkhand.
• Documenting and dissemination of challenges encountered and leadership demonstrated from TI with mobile sex workers with district and state level stakeholders.

Key Issues addressed:

Issues pertaining to women's legal rights and protection, gender equity in HIV/AIDS activities and services, and women's access to income and productive resources cross cut all components of the MASBOOT TI program. The FSWs are counseled and motivated not only to access STI services and HIV testing, but also encouraged to bring in their partners for the same. Partner notification and partner STI treatment in the field have been a challenging issue. Community mobilization is an integral component to create awareness of one's rights. FSW SHGs will be strengthened and educated on microenterprise development through partnerships with organizations working in this area.

Project Achievements and Innovations:
• Conducted Hot Spot mapping of Ranchi, Hazaribag and Dhanbad district's sex work setting in accordance with NACP III guidelines.
• Development of a Peer Educators' card for semi literate and the illiterate peer educators.
• 2,763 Commercial sex workers reached with outreach activities in the three districts.
• Organized the greater involvement of people living with HIV/AIDS (GIPA) workshop in partnership with

Indian Association of People Living with HIV/AIDS (INP+).
• Facilitated the election of three district level networks of positive people in Hazaribag, Koderma and Giridih.
• 55 peer educators and 18 partners NGO staff members provided need-based training on HIV and AIDS, STI counseling and testing.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9349	**Mechanism Name: ITECH**
Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration	Procurement Type: Cooperative Agreement
Prime Partner Name: University of Washington	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,100,000

Funding Source	Funding Amount
GHCS (State)	1,100,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The I-TECH India program is located in Chennai and is affiliated with the University of Washington, Seattle and the University of California, San Francisco. I-TECH India has received PEPFAR funding since 2003 to support work in India to halt and reverse the HIV/AIDS epidemic. I-TECH aims to enhance the quality of HIV training activities in India, particularly in high-prevalence states, through: capacity building and systems strengthening with national, regional, and local training centers; and clinical mentoring visits at hospitals, anti-retroviral treatment centers, non-governmental organizations, and other health centers.

Key Ongoing Activities:
I-TECH India is co-located at the Government Hospital of Thoracic Medicine (GHTM) in Chennai. I-TECH is implementing and supporting activities in Tamil Nadu (TN), Andhra Pradesh (AP), and Maharashtra; all of which are high HIV-burden states in India. All current and planned activities are developed and implemented in collaboration with key government and non-government of India entities and other stakeholders with emphasis placed on evidence-based and sustainable programming. I-TECH employs 24 staff, broken down as: clinicians; curriculum and training specialists; monitoring and evaluation experts; and program managers. They are engaged in delivering the following programs:
• Clinical training and technical assistance in partnership with the National AIDS Control Organization NACO. This includes supporting NACO's rollout of Centers of Excellence (COE) in HIV care, treatment, and support. I-TECH supports establishing and integrating quality HIV human capacity development activities into clinical training programs at COEs.
• Supporting GHTM as a national COE through its HIV clinical fellowship and other system support including the health management information system (HMIS) since 2004.
• NACO ART medical officer (MO) and specialist training (since 2004)
• Clinical mentorship program with Tamil Nadu State AIDS Control Society (TNSACS) (since 2007)
• Empowering Nurses to Deliver HIV/AIDS Nursing Care and Education (ENHANCE) (since 2007)
• Follow-up counseling training toolkit training curriculum (2007)
• Nurse Infection Control Education (NICE) (since 2008)
• Indian Nurse Specialist in HIV/AIDS and ART (INSHAA) (since 2008)
• Clinician consultation warmline (since May 2008)

• Training program development workshop series (since June 2008)

Project Achievements and Innovations:
• I-TECH developed and implemented an innovative and comprehensive one-year HIV clinical fellowship program to prepare junior and mid-level physicians to be leaders in HIV-related care, support, education, and research. To date, 42 fellows (three batches) have graduated. Currently, seven fellows are undergoing advanced training on HIV/AIDS care, treatment, and support. I-TECH conducts continuous quality improvement approaches to ensure programmatic improvement and to assess program outputs and outcomes.
• I-TECH conducted clinical training and consultations for ART MO. These trainings, which use I-TECH developed curricula, have trained 527 MOs and specialists including: 129 MOs, 52 link ART center MOs and 335 specialists. In addition, 11 MOs underwent HIV care and treatment refresher training where I-TECH provided technical support.

• I-TECH developed and implemented an innovative telephone consultation 'Warmline' service for HIV clinicians to provide rapid and expert consultation to HIV/AIDS care and treatment health workers. To date, 337 calls have been received from HIV care and treatment centers.

• I-TECH developed three curricula to expand the role of nurses and promote task-shifting, a key area of focus in PEPFAR II: a 13-module training for nurses on HIV/AIDS care, ENHANCE, and a hands-on infection-control curriculum, NICE. The trainings serve to enhance HIV care and treatment knowledge and skills and encourage greater involvement of nurses in HIV care and treatment. To date, 441 nurses at four tertiary care centers were trained using the ENHANCE curricula and 114 nurses were trained through the NICE program. The INSHAA is a four week intensive training and clinical mentoring program to address training gaps and needs of nurses in ART centers and Community Care Centers (CCCs) according to NACO operational guidelines. An outcome evaluation of the pilot training activity is planned for FY2010.

• I-TECH designed and piloted a series of short workshops to support systems strengthening activities that address topics such as facilitation skills, ADDIE model for curriculum development, training program development and implementation, and monitoring and evaluation (M&E) of training programs. To date, 40 people have been trained in with these workshops.

I-TECH will continue to leverage its domestic and international technical expertise in human capacity development to support India to build sustainable workforce capacity to deliver HIV/AIDS prevention, care and treatment that include pre-service and in-service training and training for task-shifting; management and leadership development. Special emphasis is placed on developing evidence-based and sustainable

programs that can be adopted and replicated throughout the country, both key priorities under PEPFAR II. I-TECH will look to expand its role in NACO and SACs as a technical expert in human capacity development (clinical and non-clinical) to ensure cost effective expansion of the above described programs.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	845,000

Key Issues

Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
TB

Budget Code Information

Mechanism ID:	**9349**		
Mechanism Name:	**ITECH**		
Prime Partner Name:	**University of Washington**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	325,000	

Narrative:

SUMMARY
The National AIDS Control Organization (NACO) estimates that there are 2.3 million people living with HIV (PLHIV) in India, all of which require care and support services. Under the National AIDS Control Program Phase III (NACP III), NACO is enhancing the role of Community Care Centers (CCCs) to provide monitoring, follow-up, and counseling support to those who are initiated on ART, positive prevention, drug adherence, and nutrition counseling. NACO is also creating Link antiretroviral therapy (ART) Centers (LACs) to provide expanded access to HIV care and treatment services, in addition to services provided through the 217 ART Centers. By 2011, NACO plans to have 350 CCCs, 250 ART centers and approximately 500 LACs.

To support the need for increased capacity among health care providers (HCP) at these care and treatment centers and to build the capacity of leaders in the field of HIV, I-TECH India aims to train clinicians on key aspects of palliative care, including prevention with positives, opportunistic infection (OI) prophylaxis, treatment, and referral, nutrition counseling and psychosocial support. I-TECH India will support the following USG-funded activities: 1) NACO Trainings for HIV Specialists and ART Center, LAC and CCC medical officers (MOs), 2) Clinical mentorship for CCC and LAC MOs, 3) the Indian nurse specialists in HIV/AIDS and ART (INSHAA) training program, and 4) an HIV fellowship program for physicians.

ACTIVITIES AND EXPECTED RESULTS

ACTIVITY 1: NACO TRAININGS

The Government Hospital of Thoracic Medicine (GHTM) training center, which is housed at national Center of Excellence (COE), hosts trainings on behalf of NACO for HIV specialists and ART, LAC, and CCC MOs, with technical support from I-TECH. Since 2004, GHTM and I-TECH have jointly conducted a total of 32 NACO trainings for 720 clinicians including: 20 HIV specialist trainings (546 participants), seven ART MO trainings (104 participants), one ART MO Refresher training (11 participants), two LACO MO trainings (52 participants) and one CCC MO training (7 participants).

Curriculum Development: I-TECH has already developed the NACO ART MO and HIV Specialist training curricula, which is now implemented at training centers and COEs nationwide. In FY09, I-TECH developed, piloted and finalized the ART MO refresher course, with support from WHO and USG. In FY10, I-TECH will advocate with NACO to disseminate the ART MO refresher course nationally. As HIV care and treatment is being scaled-up by creating LACs and expanding the role of CCCs, MOs at these facilities will require additional training in diagnosis and treatment of opportunistic infections (OIs), including TB, provision of psychosocial support and nutrition counseling, and referral for treatment and social services.
At present the four day LAC and CCC MO trainings are being conducted using a modified version of the two week ART MO curriculum. To ensure that LAC and CCC MOs have the knowledge and skills necessary to carry out their responsibilities and as per PEPFAR II guidelines for human resources for health (HRH) in-service trainings, these trainings should be linked to the core competencies of the MOs' job description and the resources available at their sites. In FY09, the NACO COE consultant drafted an outline for the LAC and CCC MO courses. I-TECH will continue to advocate for these courses throughout the year during monthly visits with NACO. In FY11, I-TECH will provide technical assistance to six training centers/centers of excellence (TC/COE) in implementing the LAC and CCC MO curricula.

Training: Over time, I-TECH has helped develop capacity of GHTM in organizing NACO trainings by mentoring the GHTM Training Coordinator, who is now handling all training logistics. In FY10, I-TECH will continue to build the capacity of the GHTM training coordinator to monitor and evaluate the trainings. I-TECH will also provide resource faculty, including the fellows, for the NACO trainings at GHTM. During FY10, I-TECH plans to support GHTM in conducting six NACO trainings (120 participants). In FY11, I-TECH will continue to support GHTM by providing resource faculty, but will no longer support the GHTM training coordinator in monitoring and evaluating the trainings, as the necessary capacity will have been built.

Warmline: In May 2008, I-TECH launched Warmline, a phone line devoted to expert, up-to-date HIV care and treatment clinical consultations. Since inception, the Warmline has received 337 calls from 48 different ART centers and two CCCs, with 79% of callers being ART and CCC MOs. The Warmline is advertised at all NACO trainings and is a key activity in providing on-going support (identified as priority for in-service trainings per PEPFAR II) to MOs after they complete their training course. In FY10, I-TECH will continue to provide on-going support to MOs and others through continued implementation of the Warmline. In FY10 I-TECH will conduct a rapid distance learning (DL) needs assessment to explore the possibility of implementing DL activities, such as the Warmline, at TC/COEs. Depending on the results of the assessment, the Warmline may then be scaled-up nationally in FY2011.

ACTIVITY 2: CLINICAL MENTORSHIP FOR LAC & CCC MOs

To enhance the quality of comprehensive care to PLHIVs, LAC and CCC MOs will require on-site clinical mentoring in addition to training. In FY10, I-TECH will continue to conduct computerized management (CM) activities for LAC and CCC MOs as a follow on to the four-day training. In FY11, I-TECH will continue these activities, and look to expand CM activities to other COE sites.

ACTIVITY 3: INDIAN NURSE SPECIALISTS IN HIV/AIDS AND ART (INSHAA)

INSHAA is a four-week intensive training program which has didactic, practicum and on-site mentoring components. The course is designed to task shift nurses' roles and responsibilities in ART Centers and CCCs. In FY09, I-TECH developed a draft curriculum for the didactic training and practicum components which are currently under review by NACO, the Indian Nursing Council (INC) and the US Center for Disease Control and Prevention Global AIDS Program (CDC-GAP).

In FY10, I-TECH will conduct a pilot training in Andhra Pradesh. This pilot will include a Training of Trainers model to train potential nurses as INSHAA trainers and mentors in order to support sustainability of the INSHAA program. I-TECH will conduct a comprehensive pilot evaluation to inform future scale-up

and determine the effectiveness of training in task-shifting care of HIV patients to INSHAA-trained nurses. After completion of the evaluation the materials will be revised and finalized for dissemination. In FY11, INSHAA will be rolled-out in several high prevalence states. While I-TECH will not be leading this roll-out process, I-TECH is in a unique position to provide TA for implementation of INSHAA.

ACTIVITY 4: HIV FELLOWSHIP PROGRAM

The GHTM/I-TECH HIV Fellowship Program, which was launched in 2005, is an innovative one-year residential clinical and leadership training program jointly sponsored by the Government of Tamil Nadu and CDC-GAP. The program includes daily hands-on HIV patient care at GHTM, didactic afternoon sessions, weekly hospital case presentations, and exposure visits to public health programs, among other diverse training experiences.

Fellowship Year 5: In FY10, I-TECH will continue the fellowship program into year five by recruiting up to 12 physicians. To date, 42 Fellows (three batches) have graduated and seven Fellows are currently in the program. As of May 2008, 62% of fellows from years one and two of the fellowship program were working in HIV/AIDS in various capacities as clinicians, researchers, and managers, contributing to the HRH goals and NACP III priorities. In FY11, I-TECH plans to implement Year 6 of the Fellowship, continuing to optimize the program through ongoing evaluations and continuous quality improvement activities.

Fellowship Accreditation : Lack of accreditation is a major barrier in attracting applicants and ensuring that fellows are able to obtain appropriate placements in HIV programs after completion of the fellowship program. In addition, accreditation of programs has been recognized in PEPFAR II as critical to assure consistency of training, improve the quality of training, and serve as retention initiative for HCPs. In FY10, I-TECH will continue to establish partnerships with local universities, such as Tamil Nadu Dr. MGR Medical University, to obtain university accreditation. If accreditation is obtained in FY2010, this activity will not be continued in FY2011.

Fellowship Program – Second Track : In FY2010, I-TECH will conduct a needs assessment for a modified fellowship track. The target cadre for the second track will be physicians who, due to distance or professional obligations, are unable to participate in the year-long fellowship program. The assessment will include collaboration with NACO, COE leadership, and stakeholders to determine identification of training objectives, appropriate program models, and geographic locations for piloting and roll-out of the program. Based on the assessment I-TECH will develop a concept paper for the second track model and advocate for implementation. In FY2011, I-TECH will pilot the second track fellowship at two locations, which would be either TC/COEs or medical colleges.

ACTIVITY 5: HIV/AIDS POCKET GUIDE

In 2005, I-TECH developed the HIV/AIDS Pocket Guide for Physicians that contains the NACO and WHO HIV/AIDS care and treatment guidelines and information on ART, prophylaxis and treatment of common OIs. In FY09, I-TECH began revision of the guide to include the updated NACO guidelines on second line ART. In FY10, I- TECH plans to complete the revision of the HIV/AIDS Pocket Guide, devise a dissemination plan, print 1,000 copies, and release the new version nationally. In FY11, I-TECH will continue to reprint the guide as needed to ensure adequate supply.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	400,000	

Narrative:

SUMMARY

The National AIDS Control Organization (NACO) estimates that there are 2.3 million people living with HIV (PLHIV) in India, all of which require care and support services. Under the National AIDS Control Program Phase III (NACP III), NACO is enhancing the role of Community Care Centers (CCCs) to provide monitoring, follow-up, and counseling support to those who are initiated on antiretroviral therapy (ART), positive prevention, drug adherence, and nutrition counseling. NACO is also creating Link ART Centers (LACs) to provide expanded access to HIV care and treatment services, in addition to services provided through the 217 ART Centers. By 2011, NACO plans to have 350 CCCs, 250 ART Centers and approximately 500 LACs.

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At present the four day LAC and CCC MO trainings are being conducted using a modified version of the two week ART MO curriculum. To ensure that LAC and CCC MOs have the knowledge and skills necessary to carry out their responsibilities and as per PEPFAR II guidelines for HRH in-service trainings, these trainings should be linked to the core competencies of these MO's job description and the resources available at their sites. In FY2009, the NACO COE consultant drafted an outline for the LAC and CCC MO courses. I-TECH will continue to advocate for these courses throughout the year during monthly visits with NACO. In FY2011, I-TECH will provide technical assistance to six TC/COEs in implementing the LAC and CCC MO curricula.

Training : Over time, I-TECH has helped develop the capacity of GHTM in organizing NACO trainings by mentoring the GHTM training coordinator, who is now handling all training logistics. In FY10, I-TECH will continue to build the capacity of the GHTM training coordinator to monitor and evaluate the trainings. I-TECH will also provide resource faculty, including the Fellows, for the NACO trainings at GHTM. During FY10, I-TECH plans to support GHTM in conducting six NACO trainings (120 participants). In FY11, I-TECH will continue to support GHTM by providing resource faculty, but will no longer support the GHTM training coordinator in monitoring and evaluating the trainings, as the necessary capacity will have been built.

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sessions, weekly hospital case presentations, and exposure visits to public health programs, among other diverse training experiences.

Fellowship Year 5: In FY10, I-TECH will continue the fellowship program into year five by recruiting up to 12 physicians. To date, 42 fellows (three batches) have graduated and seven fellows are currently in the program. As of May 2008, 62% of fellows from years one and two of the fellowship program were working in the HIV/AIDS field as clinicians, researchers, and managers, contributing to the human resources for health (HRH) goals and NACP III priorities. In FY11, I-TECH plans to implement year six of the fellowship, continuing to optimize the program through ongoing evaluations and quality improvement activities.

Fellowship Accreditation : Lack of accreditation is a major barrier in attracting applicants and ensuring that fellows are able to obtain appropriate placements in HIV programs after completion of the fellowship program. In addition, accreditation of programs has been recognized in PEPFAR II as critical to assuring consistency of training, improve the quality of training, and serve as retention initiative for HCPs. In FY2010, I-TECH will continue to establish partnerships with local universities, such as Tamil Nadu Dr. MGR Medical University, to obtain university accreditation. If accreditation is obtained in FY2010, this activity will not be continued in FY2011.

Fellowship Program – Second Track :In FY2010, I-TECH will conduct an assessment for a modified fellowship track. The target cadre for the second track will be physicians who, due to distance or professional obligations, are unable to participate in the year-long fellowship program. The assessment will include collaboration with NACO, COE leadership, and stakeholders to determine identification of training objectives, appropriate program models, and geographic locations for piloting and roll-out of the program. Based on the findings, I-TECH will develop a concept paper for the second track model and advocate for implementation. In FY2011, I-TECH will pilot the second track fellowship at two locations, which would be either TC/COEs or medical colleges.

ACTIVITY 5: HIV/AIDS POCKET GUIDE

In 2005, I-TECH developed the HIV/AIDS Pocket Guide for Physicians that contains the NACO and WHO HIV/AIDS care and treatment guidelines and information on ART, prophylaxis and treatment of common opportunistic infections (OIs). In FY09, I-TECH began revision of the guide to include the updated NACO guidelines on second line ART. In FY10, I- TECH plans to complete the revision of the HIV/AIDS Pocket Guide, devise a dissemination plan, print 1000 copies, and release the new version nationally. In FY11, I-TECH will continue to reprint the guide as needed to ensure adequate supply.he guide as needed to

ensure adequate supply.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	22,000	

Narrative:

SUMMARY

The National AIDS Control Organization (NACO) estimates that there are 2.3 million people living with HIV (PLHIV) in India, all of which require care and support services. Under the National AIDS Control Program Phase III (NACP III), NACO is enhancing the role of Community Care Centers (CCCs) to provide monitoring, follow-up, and counseling support to those who are initiated on antiretroviral therapy (ART), positive prevention, drug adherence, and nutrition counseling. NACO is also creating Link ART Centers (LACs) to provide expanded access to HIV care and treatment services, in addition to services provided through the 217 ART Centers. By 2011, NACO plans to have 350 CCCs, 250 ART Centers and approximately 500 LACs.

To support the need for increased capacity among health care providers (HCPs) at these care and treatment centers and to build the capacity of leaders in the field of HIV, I-TECH India aims to train clinicians on key aspects of palliative care, including prevention with positives, opportunistic infection (OI) prophylaxis, treatment, referral, nutrition counseling and psychosocial support. I-TECH India will support the following USG-funded activities: 1) NACO Trainings for HIV and ART center specialists, LAC and CCC medical officers (MOs); 2) clinical mentorship for CCC and LAC MOs; 3) the Indian Nurse Specialists in HIV/AIDS and ART (INSHAA) training program; and 4) an HIV Fellowship Program for physicians.

ACTIVITIES AND EXPECTED RESULTS

ACTIVITY 1: NACO TRAININGS

The Government Hospital of Thoracic Medicine (GHTM) Training Center, which is housed at national Center of Excellence (COE), hosts trainings on behalf of NACO for HIV specialists and ART, LAC, and CCC MOs, with technical support from I-TECH. Since 2004, GHTM and I-TECH have jointly conducted a total of 32 NACO trainings for 720 clinicians including: 20 HIV specialist trainings (546 participants), seven ART MO trainings (104 participants), one ART MO refresher training (11 participants), two LACO MO trainings (52 participants) and one CCC MO training (7 participants).

Curriculum Development :

I-TECH developed the NACO ART MO and HIV specialist training curricula, which is now implemented at training centers and COEs nationwide. In FY09, I-TECH developed, piloted and finalized the ART MO refresher course, with support from WHO and USG. In FY10, I-TECH will advocate with NACO to disseminate the ART MO refresher course nationally. As HIV care and treatment is being scaled-up by creating LACs and expanding the role of CCCs, MOs at these facilities will require additional training in monitoring patients on ART, dispensing ART drugs, recognition of side effects identification of drug interactions, ART adherence counseling and referral of complicated cases to ART centers, in addition to care and support topics.

At present the four day LAC and CCC MO trainings are being conducted using a modified version of the two week ART MO curriculum. To ensure that LAC and CCC MOs have the knowledge and skills necessary to carry out their responsibilities and as per PEPFAR II guidelines for HRH in-service trainings, these trainings should be linked to the core competencies of these MO's job description and the resources available at their sites. In FY2009, the NACO COE consultant drafted an outline for the LAC and CCC MO courses. I-TECH will continue to advocate for these courses throughout the year during monthly visits with NACO. In FY2011, I-TECH will provide technical assistance to six TC/COEs in implementing the LAC and CCC MO curricula.

Training : Over time, I-TECH has helped develop the capacity of GHTM in organizing NACO trainings by mentoring the GHTM training coordinator, who is now handling all training logistics. In FY10, I-TECH will continue to build the capacity of the GHTM training coordinator to monitor and evaluate the trainings. I-TECH will also provide resource faculty, including the Fellows, for the NACO trainings at GHTM. During FY10, I-TECH plans to support GHTM in conducting six NACO trainings (120 participants). In FY11, I-TECH will continue to support GHTM by providing resource faculty, but will no longer support the GHTM training coordinator in monitoring and evaluating the trainings, as the necessary capacity will have been built.

Warmline : In May 2008, I-TECH launched the Warmline, a phone line devoted to expert, up-to-date HIV care and treatment clinical consultations. Since inception, the Warmline has received 337 calls from 48 different ART centers and 2 CCCs, with 79% of callers being ART and CCC MOs. The Warmline is advertised at all NACO trainings and is a key activity in providing on-going support (identified as priority for in-service trainings per PEPFAR II) to MOs after they complete their training course. In FY2010, I-TECH will continue to provide on-going support to MOs and others through continued implementation of the Warmline. In FY2010 I-TECH will conduct a rapid distance learning (DL) needs assessment to explore the possibility of implementing DL activities, such as the Warmline, at TC/COEs. Depending on the results of the assessment, the Warmline may then be scaled-up nationally in FY2011.

ACTIVITY 2: CLINICAL MENTORSHIP FOR LAC & CCC MOs

To enhance the quality of comprehensive care to PLHIVs, LAC and CCC MOs will require on-site clinical mentoring in addition to training. In FY2010, I-TECH will continue to conduct CM activities for LAC and CCC MOs as follow-on to the four-day training. In FY2011, I-TECH will continue these activities, and look to expand CM activities to other COE sites.

ACTIVITY 3: INDIAN NURSE SPECIALISTS IN HIV/AIDS AND ART (INSHAA)

INSHAA is a four week intensive training program which has didactic, practicum and on-site mentoring components. The course is designed to task shift nurses' roles and responsibilities in ART centers and CCCs. In FY09, I-TECH developed a draft curriculum for the didactic training and practicum components which is currently under review by NACO, the Indian Nursing Council (INC) and the US Center for Disease Control and Prevention Global AIDS Program (CDC-GAP).

In FY10, I-TECH will conduct a pilot training in Andhra Pradesh. This pilot will include a Training of Trainers model to train potential nurses as INSHAA trainers and mentors in order to support sustainability of the INSHAA program. I-TECH will conduct a comprehensive pilot evaluation to inform future scale-up and determine the effectiveness of training in task-shifting care of HIV patients to INSHAA-trained nurses. After completion of the evaluation the materials will be revised and finalized for dissemination. In FY11, INSHAA will be rolled-out in several high prevalence states. While I-TECH will not be leading this roll-out process, I-TECH is in a unique position to provide technical assistance (TA) for implementation of INSHAA.

ACTIVITY 4: HIV FELLOWSHIP PROGRAM

The GHTM/I-TECH HIV Fellowship Program, which was launched in 2005, is an innovative one-year residential clinical and leadership training program jointly sponsored by the Government of Tamil Nadu and CDC-GAP. The program includes daily hands-on HIV patient care at GHTM, didactic afternoon sessions, weekly hospital case presentations, and exposure visits to public health programs, among other diverse training experiences.

Fellowship Year 5 : In FY10, I-TECH will continue the fellowship program into year five by recruiting up to 12 physicians. To date, 42 fellows (three batches) have graduated and seven fellows are currently in the

program. As of May 2008, 62% of fellows from years one and two of the fellowship program were working in the HIV/AIDS field as clinicians, researchers, and managers, contributing to the human resources for health (HRH) goals and NACP III priorities. In FY11, I-TECH plans to implement year six of the fellowship, continuing to optimize the program through ongoing evaluations and quality improvement activities.

Fellowship Accreditation : Lack of accreditation is a major barrier in attracting applicants and ensuring that fellows are able to obtain appropriate placements in HIV programs after completion of the fellowship program. In addition, accreditation of programs has been recognized in PEPFAR II as critical to assuring consistency of training, improve the quality of training, and serve as retention initiative for HCPs. In FY2010, I-TECH will continue to establish partnerships with local universities, such as Tamil Nadu Dr. MGR Medical University, to obtain university accreditation. If accreditation is obtained in FY2010, this activity will not be continued in FY2011.

Fellowship Program – Second Track : In FY2010, I-TECH will conduct an assessment for a modified fellowship track. The target cadre for the second track will be physicians who, due to distance or professional obligations, are unable to participate in the year-long fellowship program. The assessment will include collaboration with NACO, COE leadership, and stakeholders to determine identification of training objectives, appropriate program models, and geographic locations for piloting and roll-out of the program. Based on the findings, I-TECH will develop a concept paper for the second track model and advocate for implementation. In FY2011, I-TECH will pilot the second track fellowship at two locations, which would be either TC/COEs or medical colleges.

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Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	22,000	

Narrative:

SUMMARY
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The Government Hospital of Thoracic Medicine (GHTM) Training Center, which is housed at national Center of Excellence (COE), hosts trainings on behalf of NACO for HIV Specialists and ART, LAC, and CCC medical officers (MOs), with technical support from I-TECH. Since 2004, GHTM and I-TECH have jointly conducted a total of 32 NACO trainings for 720 clinicians including: 20 HIV specialist trainings (546 participants), seven ART MO trainings (104 participants), one ART MO refresher training (11 participants), two LACO MO trainings (52 participants) and one CCC MO training (7 participants).

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social services.

At present the four day LAC and CCC MO trainings are being conducted using a modified version of the two week ART MO curriculum. To ensure that LAC and CCC MOs have the knowledge and skills necessary to carry out their responsibilities and as per PEPFAR II guidelines for HRH in-service trainings, these trainings should be linked to the core competencies of these MOs' job description and the resources available at their sites. In FY09, the NACO COE consultant drafted an outline for the LAC and CCC MO courses. I-TECH will continue to advocate for these courses throughout the year during monthly visits with NACO. In FY11, I-TECH will provide technical assistance to six TC/COEs in implementing the LAC and CCC MO curricula.

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Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	35,000	

Narrative:

SUMMARY

To support the National AIDS Control Organization (NACO) priority area of increased capacity on monitoring and evaluation, surveillance and research, the International Training and Education Center on HIV (I-TECH) will continue its collaboration with the Government Hospital of Thoracic Medicine (GHTM) and increase its technical support of the Tamil Nadu State AIDS Control Society (TANSACS). These activities will serve to improve the quality of data provided to state and national HIV/AIDS control organizations requested through the National AIDS Control Program III (NACP III) Evaluation Plan, in

addition to providing increased effectiveness of data systems that support patient monitoring, program monitoring and evaluation, programmatic level advocacy, policy development as well as dissemination of findings through mediums such as technical conferences and peer-reviewed journals.

ACTIVITIES AND EXPECTED RESULTS

ACTIVITY 1: TB/HIV Information System (T/HIS) Management, Quality Improvement and Operations Research Support to GHTM

In FY10, I-TECH, in collaboration with the State of Tamil Nadu and Government of India, will continue to support and develop the T/HIS, the electronic health management information system at GHTM, India's largest HIV care and treatment facility. The objective of this system is to improve the efficiency and effectiveness of care provided to these patients and to routinely provide high quality program level data to the facility, state, and national HIV/AIDS control organizations; data which are both complex and rarely available in India. This computerized T/HIS provides comprehensive, longitudinal patient data to more efficiently provide information on follow-up patient care and outcomes. Collectively, I-TECH's activities ensure high quality data management and ongoing use of the data to improve the quality of care at GHTM, as well as use of the data to inform state and national policies and practices to improve quality of HIV/AIDS care on a larger scale.

In FY2010, I-TECH will provide technical assistance (TA) to oversee the technical and operational management of the T/HIS at GHTM. This TA will be provided through key technical staff (epidemiologist, data-base administer (DBA), statistician). I-TECH, in collaboration with the GHTM management team, will coordinate and supervise these technical personnel to ensure appropriate data collection, analysis, and utilization of this patient database at the hospital by key stakeholders as well as continued system development as per the need of the program.

To facilitate T/HIS quality assurance, as well as data use and dissemination, in FY2010, I-TECH will conduct monthly data quality audits and provide training for 27 T/HIS data entry operators related to accurate data collection and entry into the T/HIS system. I-TECH will also train 20 GHTM clinical staff, 12 I-TECH clinical fellows, and 12 state and national program staff, in utilizing and accessing the T/HIS to develop their skills in data analysis and technical writing. An additional objective of this training is the increased use of the system to improve patient care and decision-making through the analysis, interpretation, and dissemination of patient and population data from the system. To further increase data use and subsequent sustainability of the T/HIS system, I-TECH will facilitate appropriate access to the system for approved analysis that can be used for quality improvement of service provision at GHTM as well as to disseminate programmatically relevant findings.

In FY2010, I-TECH will continue to support the development of on-going operations research and quality improvement activities utilizing the T/HIS by participating in the GHTM Institutional Review Board (IRB), which it successfully helped to develop in FY2008, as well as begin participation with the newly-developed Quality Improvement Technical Working Group at GHTM, which guides operations research and quality improvement activities within GHTM.

These training and technical assistance activities will result in at least two technical papers of publishable quality are being developed in FY2010.

In FY2011, I-TECH will continue its efforts in supporting the GHTM to ensure high quality T/HIS data management and on-going use of the T/HIS data to improve the quality of care at GHTM, as well as use of the data to inform state and national policies and practices to improve quality of HIV/AIDS care on a larger scale.

ACTIVITY 2: Targeted support to Tamil Nadu State AIDS Control Society (TANSACS)

Strategic Information Technical Assistance
TANSACS has requested I-TECH's assistance in building its capacity in strategic information and in conducting training. TANSACS is the nodal agency for HIV program strategic information (i.e. monitoring and evaluation, HMIS, surveillance) in the state of Tamil Nadu. In order to operationalize this mandate, I-TECH has contributed TA to TANSACS for collecting, analyzing, and interpreting program data in the state. Despite significant improvement, several factors have limited the optimal utilization of TANSACS program data. These factors include: limited human resources, limited technical capacity, and the collection of increasingly larger and more complex program data. To date, I-TECH has supported specific activities to address these factors including: technical support to the newly established Strategic Information Management Unit (SIMU) and ongoing TA to their monitoring and evaluation (M&E) officer, TA to establish an operational research funding and coordinating committee (TORCH), and development and implementation of a web-based computerized management information system (CMIS).

In FY2010, I-TECH staff will continue to provide TA to TANSACS to improve appropriate use of program data, including continuation of the above activities. Additional specific activities as requested by TANSACS will include TA to the SIMU to build institutional capacity in: program data management, analysis, and interpretation; statistical support; and program evaluation design and implementation. It is expected that such support will result in a sustained culture of appropriate data use and dissemination by TANSACS, a key priority area under NACPIII. In FY2011, I-TECH will continue support and technical assistance to TANSACS and SIMU as requested. In FY2011, I-TECH will continue to provide TA to

TANSACS, increasingly building capacity of staff to ensure sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	206,000	

Narrative:

SUMMARY

Under the National AIDS Control Program Phase III (NACP III), the National AIDS Control Organization (NACO) is expanding provision of care, support and treatment by increasing the number antiretroviral (ART) Centers and Community Care Centers (CCCs); enhancing the role of CCCs in providing monitoring, follow-up, and counseling support to ART patients; creating a new type of facility called Link ART Centers (LACs). By 2011, NACO plans to have 350 CCCs, 250 ART Centers and approximately 500 LACs.

To develop the human resources for health (HRH) needed to support this expansion, NACO plans to designate seven additional Training Centers and Centers of Excellence (TC/COEs) to complement the existing 13. To support the current TC/COEs and the expansion of new TC/COEs, I-TECH will support the following USG-funded activities: 1) COE development and 2) support to GHTM and other partner organizations on: a) infection control, b) coordination and implementation of training programs, and c) quality improvement and evaluation.

ACTIVITIES AND EXPECTED RESULTS

ACTIVITY 1: Center of Excellence Development

In FY2009, I-TECH supported 13 existing TC/COEs through provision of a NACO Consultant who, by the end of FY2009, will have developed TC/COE core capacities based on NACO guidelines and completed an overall needs assessment at the 13 TC/COEs. Based on I-TECH's experience supporting GHTM as a COE, I-TECH will develop a comprehensive plan to build the capacity of the TC/COEs in India and to improve infrastructure to increase training capacity.

Training TC/COE Staff: In FY2010, I-TECH will conduct a training needs assessment (TNA) for each TC/COE. As the TNAs for each COE are completed, I-TECH will work closely with each TC/COE to develop a comprehensive training plan for TC/COE staff and begin HIV trainings with the goal of making each institution a more effective support mechanism for the ART, LAC and CCCs in the region. In FY2011, I-TECH will complete the TNAs for the 13 existing TC/COEs and conduct additional assessments for TC/COEs as they are established. I-TECH will also continue to develop training plans

with TC/COEs as the TNAs are completed, finalize plans for the 13 TC/COEs by the end of FY11 and begin training of staff.

Distance Learning (DL) Assessment: DL is a powerful tool in providing ongoing training and support to improve the HIV-related knowledge and skills of the healthcare providers (HCPs). Globally, I-TECH supports DL activities in nine countries and is implementing a biweekly web-based HIV/AIDS Clinical Seminar Series (www.globalhivlearning.org) with an average of 86 participants from around the world. I-TECH previously conducted similar DL needs assessments in Tanzania, Mozambique and Trinidad and Tobago. I-TECH will conduct a rapid DL needs assessment at the TC/COEs in FY2010 which will: 1) Explore various DL methods (web-based seminar and courses, telemedicine, and Warmline) to determine which method(s) provide the type of support needed by HCPs and 2) assess capacity of the TC/COEs to create, implement and support DL programs. I-TECH will disseminate findings and hold discussions with stakeholders to determine a plan for DL. At the request of NACO, I-TECH will also explore implementation of a clinical seminar series similar to the I-TECH HIV/AIDS Clinical Seminar Series. In FY11, I-TECH plans to provide technical assistance (TA) to NACO in implementing additional DL technologies as identified by the assessment.

NACO Consultants: In FY2010 and FY2011, I-TECH will support three NACO consultants: a lead clinical consultant, a deputy clinical consultant, and a training coordinator. In FY2010, the lead and deputy clinical consultants will utilize the findings of the TC/COE overall needs assessments in FY2009 to develop a capacity building plan for the TC/COEs. The lead clinical consultant will also coordinate with national and local stakeholders, including NACO, state AIDS control societies (SACS), Center for Disease Control Global AIDS Program (CDC-GAP), TC/COE leadership, and people living with HIV/AIDS (PLHIV) networks to create a research agenda for the 13 TC/COEs and document best practices of the national ART program, and serve as a resource person for NACO trainings at the TC/COEs. The deputy clinical consultant will primarily be responsible for providing on-going TA for the TC/COEs in implementing their capacity building plans.

Based on the NACP III guidance and the capacity building plans, the training coordinator will work with SACS and TC/COE training coordinators to develop a national training schedule and provide TA as trainings are implemented. This TA will include assistance in: training schedule preparation, identification of resource persons, review of training reports, and sharing of best practices/lessons learned. The training coordinator will also provide national-level monitoring of progress towards NACP III goals in ensuring that HCPs are adequately trained to provide high quality clinical care.

In FY2011, the lead clinical consultant will continue to support TC/COEs in creating research agendas, documenting the best practices and study results, and publication; the deputy clinical consultant will

continue to provide on-going TA for the TC/COEs, and the training coordinator will continue to support the implementation of the national training schedule by providing TA to SACS and TC/COE training coordinators.

ACTIVITY 2: GHTM SYSTEMS STRENGTHENING

Clinical Support: At GHTM I-TECH's strategy has been to develop innovative approaches for strengthening health systems and directly contribute in improved quality of care for HIV patients. I-TECH India has initiated Clinical Society Meetings (CSMs) for physicians and nurses, a Hospital Infection Control Committee (HICC) and sanitary rounds which have become institutionalized at GHTM. In FY2010, I-TECH will continue to support GHTM in these activities and continue to be an active member of the State AIDS Clinical Expert Panel (SACEP) which determines patient qualification for second line ART.

T/HIS Management, Quality Improvement, and Operations Research : In FY2010, I-TECH, in collaboration with the State of Tamil Nadu and Government of India, will continue to support the electronic TB/HIV Information System (T/HIS) health management information system at GHTM. I-TECH's activities will ensure high quality data management and on-going data use to improve the quality of care at GHTM, and use of the data to inform state and national policies and practices to improve the quality of HIV/AIDS care.

To further support the development of operations research (OR) and quality improvement (QI) activities utilizing the T/HIS, I-TECH will continue to support the GHTM Institutional Review Board and participate in the new QI Technical Working Group at GHTM. These activities will result in at least two technical papers of publishable quality in FY2010. In FY2011, I-TECH will continue its efforts in supporting the GHTM to ensure high quality T/HIS data management and ongoing data use.

ACTIVITY 3: TA TO TAMIL NADU STATE AIDS CONTROL SOCIETY (TANSACS)

Secundment of Training Manager : In coordination with TANSACS, in FY2010, I-TECH India will help to recruit and second a Training Manager to TANSACS who will coordinate training for ART, CCC, and Drop-In Center teams; prepare training schedules; design training programs for ORWs; conduct needs assessments and evaluations; and assess the quality of the training programs conducted. It is envisioned that I-TECH will provide the coordinating mechanism for the second, but the Training Manager will be report programmatically to TNSACS. I-TECH will continue to provide this level of support in FY2011.

ACTIVITY 4: Nurses Infection Control and Education (NICE)

The NICE training package addresses biomedical waste management and infection control measures as described in NACP III. It is designed to train nurses in infection control practices and empower them to advocate for changes that increase workplace safety through consistent implementation of standard precautions.

In FY09, I-TECH completed and disseminated the NICE training package and conducted trainings for 114 nurses at GHTM. In FY10, I-TECH will provide TA in rolling out NICE at Rural Development Trust (RDT) and Bel Air hospitals using a Training of Trainers (TOT) model for sustainability. At least 12 nurse leaders will receive TOT training and will train at least 50 staff nurses at their institutions (100 total). In FYII both organizations will assume responsibility after full capacity development and thus this will be a discontinued activity.

ACTIVITY 5: Infection Control Training for RDT support staff

NACP III recognizes that IC policies and standard precautions play a vital role in preventing hospital-acquired infections. It is imperative that all HCPs are oriented and trained in these areas. In FY2010, I-TECH will carry out a needs assessment at RDT to study the current IC systems and practices and to understand the knowledge and attitudes of support staff concerning IC practices and policies. The data collected in this assessment will be used to develop recommendations for improving IC at the facility, including a capacity building plan for support staff which I-TECH will then implement.

ACTIVITY 6: Organizational Capacity Building

As the HIV epidemic and response to it matures, there is increasing recognition by NACO, SACs, and NGOs for the need to support capacity development in non-clinical HIV/AIDS program areas and systems such as: program monitoring and evaluation, training development, and program management.

FY10 I-TECH will be responsive to requests for a series of non-clinical workshops to support health systems strengthening activities. The primary target for these workshops will be government partners with subsequent consideration for key NGOs. Some specific workshop topic areas that have been developed to date include: curriculum development, training program development and implementation, scientific writing and communication, and practical and appropriate monitoring and evaluation of training programs. Additional topic areas may be developed based on the needs of partner agencies. In FY2010, I-TECH will focus these activities in Tamil Nadu and Andhra Pradesh, two of the high HIV-burden states in India. In FY11, I-TECH will expand these activities to additional high-burden states.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	90,000	

Narrative:

SUMMARY

Tuberculosis (TB) is a serious public health problem in India with over 1 million cases of TB reported annually, accounting for nearly one third of the global TB burden. There is considerable overlap of the TB and HIV epidemics in India. Active TB disease is the most common opportunistic infection (OI) in people living with HIV/AIDS (PLHIV). Each year, 230,000 PLHIVs (10%) will have an episode of TB. Controlling this dual epidemic remains a major challenge for the country, and requires capacity building among health care providers (HCPs). Under the National AIDS Control Program Phase III (NACP III) the National AIDS Control Program (NACO) is expanding the number of facilities that will provide HIV related services, which include TB screening, diagnosis and treatment. In addition to expanding the number of Community Care Centers (CCCs) and antiretroviral therapy (ART) Centers, NACO is creating Link ART Centers (LACs) to decentralize provision of ART. By 2011, NACO plans to have 350 CCCs, 250 ART Centers and approximately 500 LACs.

In order to support the scale-up of TB services, as part of a comprehensive HIV care and treatment package, I-TECH will provide training and mentoring for HCPs in early recognition of signs and symptoms, diagnosis and treatment of TB. The specific target populations are physicians and nurses.

ACTIVITIES AND EXPECTED RESULTS

ACTIVITY 1: NACO TRAININGS

The Government Hospital of Thoracic Medicine (GHTM) Training Center, which is housed at national Center of Excellence (COE), hosts trainings on behalf of NACO for HIV Specialists and ART, LAC, and CCC medical officers (MOs), with technical support from I-TECH. Since 2004, GHTM and I-TECH have jointly conducted a total of 32 NACO trainings for 720 clinicians including: 20 HIV specialist trainings (546 participants), seven ART MO trainings (104 participants), one ART MO refresher training (11 participants), two LACO MO trainings (52 participants) and one CCC MO training (7 participants).

Curriculum Development: I-TECH has already developed the NACO ART MO and HIV specialist training curricula, which is now implemented at training centers and COEs nationwide. In FY2009, I-TECH developed, piloted and finalized the ART MO refresher course, with support from WHO and USG. In FY2010, I-TECH will advocate with NACO to disseminate the ART MO Refresher course nationally. As HIV care and treatment is being scaled-up by creating LACs and expanding the role of CCCs, MOs at

these facilities will require additional training in diagnosis and treatment of opportunistic infections (OIs), including TB, provision of psycho-social support and nutrition counseling, and referral for treatment and social services.

At present the four day LAC and CCC MO trainings are being conducted using a modified version of the two week ART MO curriculum. To ensure that LAC and CCC MOs have the knowledge and skills necessary to carry out their responsibilities and as per PEPFAR II guidelines for HRH in-service trainings, these trainings should be linked to the core competencies of these MOs' job description and the resources available at their sites. In FY09, the NACO COE consultant drafted an outline for the LAC and CCC MO courses. I-TECH will continue to advocate for these courses throughout the year during monthly visits with NACO. In FY11, I-TECH will provide technical assistance to six TC/COEs in implementing the LAC and CCC MO curricula.

Training : Over time, I-TECH has helped develop the capacity of GHTM in organizing NACO trainings by mentoring the GHTM training coordinator, who is now handling all training logistics. In FY10, I-TECH will continue to build the capacity of the GHTM training coordinator to monitor and evaluate the trainings. I-TECH will also provide resource faculty, including the Fellows, for the NACO trainings at GHTM. During FY10, I-TECH plans to support GHTM in conducting six NACO trainings (120 participants). In FY11, I-TECH will continue to support GHTM by providing resource faculty, but will no longer support the GHTM training coordinator in monitoring and evaluating the trainings, as the necessary capacity will have been built.

Warmline : In May 2008, I-TECH launched the Warmline, a phone line devoted to expert, up-to-date HIV care and treatment clinical consultations. Since inception, the Warmline has received 337 calls from 48 different ART centers and 2 CCCs, with 79% of callers being ART and CCC MOs. The Warmline is advertised at all NACO trainings and is a key activity in providing on-going support (identified as priority for in-service trainings per PEPFAR II) to MOs after they complete their training course. In FY2010, I-TECH will continue to provide on-going support to MOs and others through continued implementation of the Warmline. In FY2010 I-TECH will conduct a rapid distance learning (DL) needs assessment to explore the possibility of implementing DL activities, such as the Warmline, at TC/COEs. Depending on the results of the assessment, the Warmline may then be scaled-up nationally in FY2011.

ACTIVITY 2: CLINICAL MENTORSHIP FOR LAC & CCC MOs

To enhance the quality of comprehensive care to PLHIVs, LAC and CCC MOs will require on-site clinical mentoring in addition to training. In FY2010, I-TECH will continue to conduct CM activities for LAC and CCC MOs as follow-on to the four-day training. In FY2011, I-TECH will continue these activities, and

look to expand CM activities to other COE sites.

ACTIVITY 3: INDIAN NURSE SPECIALISTS IN HIV/AIDS AND ART (INSHAA)

INSHAA is a four week intensive training program which has didactic, practicum and on-site mentoring components. The course is designed to task shift nurses' roles and responsibilities in ART centers and CCCs. In FY09, I-TECH developed a draft curriculum for the didactic training and practicum components which is currently under review by NACO, the Indian Nursing Council (INC) and the US Center for Disease Control and Prevention Global AIDS Program (CDC-GAP).

In FY10, I-TECH will conduct a pilot training in Andhra Pradesh. This pilot will include a Training of Trainers model to train potential nurses as INSHAA trainers and mentors in order to support sustainability of the INSHAA program. I-TECH will conduct a comprehensive pilot evaluation to inform future scale-up and determine the effectiveness of training in task-shifting care of HIV patients to INSHAA-trained nurses. After completion of the evaluation the materials will be revised and finalized for dissemination. In FY11, INSHAA will be rolled-out in several high prevalence states. While I-TECH will not be leading this roll-out process, I-TECH is in a unique position to provide technical assistance (TA) for implementation of INSHAA.

ACTIVITY 4: HIV FELLOWSHIP PROGRAM

The GHTM/I-TECH HIV Fellowship Program, which was launched in 2005, is an innovative one-year residential clinical and leadership training program jointly sponsored by the Government of Tamil Nadu and CDC-GAP. The program includes daily hands-on HIV patient care at GHTM, didactic afternoon sessions, weekly hospital case presentations, and exposure visits to public health programs, among other diverse training experiences.

Fellowship Year 5: In FY10, I-TECH will continue the fellowship program into year five by recruiting up to 12 physicians. To date, 42 fellows (three batches) have graduated and seven fellows are currently in the program. As of May 2008, 62% of fellows from years one and two of the fellowship program were working in the HIV/AIDS field as clinicians, researchers, and managers, contributing to the human resources for health (HRH) goals and NACP III priorities. In FY11, I-TECH plans to implement year six of the fellowship, continuing to optimize the program through ongoing evaluations and quality improvement activities.

Fellowship Accreditation: Lack of accreditation is a major barrier in attracting applicants and ensuring that fellows are able to obtain appropriate placements in HIV programs after completion of the fellowship

program. In addition, accreditation of programs has been recognized in PEPFAR II as critical to assuring consistency of training, improve the quality of training, and serve as retention initiative for HCPs. In FY2010, I-TECH will continue to establish partnerships with local universities, such as Tamil Nadu Dr. MGR Medical University, to obtain university accreditation. If accreditation is obtained in FY2010, this activity will not be continued in FY2011.

Fellowship Program – Second Track : In FY2010, I-TECH will conduct an assessment for a modified fellowship track. The target cadre for the second track will be physicians who, due to distance or professional obligations, are unable to participate in the year-long fellowship program. The assessment will include collaboration with NACO, COE leadership, and stakeholders to determine identification of training objectives, appropriate program models, and geographic locations for piloting and roll-out of the program. Based on the findings, I-TECH will develop a concept paper for the second track model and advocate for implementation. In FY2011, I-TECH will pilot the second track fellowship at two locations, which would be either TC/COEs or medical colleges.

ACTIVITY 5: HIV/AIDS POCKET GUIDE

In 2005, I-TECH developed the HIV/AIDS Pocket Guide for Physicians that contains the NACO and WHO HIV/AIDS care and treatment guidelines and information on ART, prophylaxis and treatment of common opportunistic infections (OIs). In FY09, I-TECH began revision of the guide to include the updated NACO guidelines on second line ART. In FY10, I- TECH plans to complete the revision of the HIV/AIDS Pocket Guide, devise a dissemination plan, print 1000 copies, and release the new version nationally. In FY11, I-TECH will continue to reprint the guide as needed to ensure adequate supply.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9350	**Mechanism Name: PATHWAY (PCI)-COMPREHENSIVE COMMUNITY AND HOME-BASED CARE (CHBC) AND SUPPORT FOR PEOPLE LIVING WITH HIV/AIDS (PLHIV) IN INDIA**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement

Prime Partner Name: Project Concern International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Since 2004, Project Concern International is implementing PATHWAY program (Positive Action for the Health of People Living with HIV/AIDS), at six sites in five high prevalence states of India (Pune in Maharashtra, Salem in Tamil Nadu, Warangal in Andhra Pradesh, Imphal and Churachandpur in Manipur and Dimapur in Nagaland). PATHWAY is an integrated community home-based care (CHBC) and HIV prevention program, which includes the provision of health services, psychosocial support and livelihood.

The PATHWAY program sites carry out prevention activities for the general population on a continual basis and offer community support for PLHIV and their family members through formation and strengthening of PLHIV support networks; and sensitize local leaders to address the needs and issues of the PLHIV.

PCI is also working closely with the National AIDS Control Organisation (NACO) to improve and upgrade its Strategic Information System (SIS) and train its personnel in the management of SIS and other skill areas in high demand.

The project is winding up on August 31, 2010. PCI would be implementing selected activities in FY10 with the funds from the year 5 of the project. In the FY10, there would no outreach activities at the field level since the main focus in FY10 would be on (1) compiling and documenting key lessons learnt under PATHWAY project, (2) undertaking program review and assessment for recommendations on HIV policy related inputs to the National AIDS Control Program and other stakeholders through dissemination initiatives.

Key Ongoing Activities:

• Low cost CHBC has been the key activity for the PATHWAY program. The CHBC component included

medical care, nutritional support, psychosocial counseling and other basic services to PLHIV and their family members. Apart from these, the project activities also included broad based community sensitization, rapport building with other NGOs/CBOs and providing an enabling environment and community support to PLHIV.

• As per the sustainability plan (which is in place since 2004), the programmatic transition is in place and the project activities at the grassroots have been handed over to the local NGOs and CBOs at most places.

• The focus is on documenting the learning's and findings of the program. In this regard, documents on CHBC model, operational guidelines and innovations are being produced and are in the process of finalization.

Project Achievements and Innovations:

• PCI's PATHWAY project was one of the first CHBC programs in India for PLHIV, modeled on the Ugandan program in Africa. It was adapted to suit the low-prevalence HIV settings in India.
• The project reached more than 15,415 PLHIV and their family members in 40 service centers through seven implementing partners in its five years of existence.
• The project has implemented various innovative strategies for addressing stigma related issues at the grassroots that includes positive speakers bureau, initiating discussion among general population on HIV through interface with PLHIV at tea stalls and by involving private sector in developing livelihood initiatives for PLHIV.
• The project has reached out to the diverse populations such as urban slum population in Pune and tribal population in the North East. But, in spite of these diversities, the project has been able to maintain uniform standard of service delivery. The project has developed wide range of job-aids such as handouts for peer educators, quality verification checklists and policies such as waste management policy for quality assurance purposes.
• The project has been successful in providing a platform for meaningful engagement and involvement of the PLHIV in the entire program cycle, including monitoring.
• The PATHWAY program has been able to build capacities of the organizations and the individuals working in the area of HIV/AIDS. For example, more than 300 persons visited two Immersion Learning Sites established at Pune and Salem Two of PATHWAY sites (Pune and Salem) are Immersion Learning Sites (ILS) for learning on CHBC prevention, care and support. Medical students and fellows from I-TECH regularly visit project sites.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Increasing gender equity in HIV/AIDS activities and services

Increasing women's legal rights and protection

TB

Workplace Programs

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9863	**Mechanism Name: Connect (PSI)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Population Services International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 3,900,000	
Funding Source	**Funding Amount**
GHCS (State)	257,489
GHCS (USAID)	3,642,511

Sub Partner Name(s)

Dhan Foundation	Federation of Indian Chambers of	Garment Workers Union

	Commerce and Industry	Karnataka
INP+ (Indian Network of Positive)	KNP+ (Karnataka Network of Positive)	LabourNet
NMP+ (Network of Maharashtra Positive)	TBD	TNNP+ (Tamil Nadu Network of Positive People)
TNP+ (Telugu Network of Positives)	Y.R. Gaitonde Center for AIDS Research & Education	

Overview Narrative

Implementing Mechanism Narrative

The Connect project funded by USAID (October 2006 to September 2011), and implemented by Population Services International (PSI), aims to leverage and build public-private partnerships to increase the private sector response to HIV/AIDS and TB. The project is led by PSI and implemented in partnership with Y R Gaitonde Center for AIDS Research and Education (YRGCARE), University of Manitoba (UoM) and the Federation of Indian Chambers of Commerce and Industry (FICCI). The International Labor Organization (ILO) and the Revised National Tuberculosis Control Program (RNTCP) are technical support partners of the project.

Project Activities and Achievements:
The Connect Project aims to promote a vigorous commercial sector response to HIV/AIDS and TB by using the following innovative strategies of private sector engagement. The key achievements of the project are mentioned below.

1. Build public-private partnership models for motivating at-risk workers to adopt safer health practices in HIV/AIDS and TB
Connect in partnership with UoM, identified and prioritized the key economic sectors at risk for HIV in the state of Karnataka, to focus on behavior change among most at risk individuals. Over 239,000 individuals from the identified economic sectors have been reached with messages of abstinence and being faithful and over 470,000 with messages emphasizing risk reduction, especially condom use. More than 320 individuals were trained on these messages. Over 700 condom outlets, both traditional and non-traditional, have been established close to the at-risk communities leveraging the condom social marketing programs of PSI. Over 139,000 workers have been reached in the construction and garment sectors with TB (symptoms, diagnosis and treatment adherence) messages. 206 suspects got their sputum tested and all the 113 individuals who tested positive were put on directly observed treatment short-course (DOTS).

Eleven counseling and testing (CT) centers (five static and six mobile) have provided services to over 58,000 clients to date. Of the 11 centers, three in Mumbai and Vashi meet the Office of Global AIDS Coordinator (OGAC) criteria for public-private partnership. However, all the 11 centers qualify as a public-private partnership as per National AIDS Control Program (NACP III) guidelines and are involved in a collaboration with the local State AIDS Control Societies (SACS). Over 280 counselors and laboratory technicians have been trained in counseling and testing according to national and international standards.

2. Mobilize increased engagement of the insurance sector in HIV/AIDS mitigation in line with NACP III
Connect designed and developed India's first group health insurance scheme for people living with HIV/AIDS (PLHIV) through a public private partnership with Star Health & Allied Insurance. The pilot insurance scheme was launched in Karnataka in April 2008. The scale-up to enroll more members is currently underway in the four high prevalence southern states of Karnataka, Tamil Nadu, Andhra Pradesh and Maharashtra, and more than 1,200 people living with HIV have been enrolled so far. Capacities of state networks in Karnataka and Maharashtra have been built for awareness and mobilization. A Memorandum of Understanding (MOU) has been signed with the Indian Network for the People Living with HIV/AIDS (INP+) for advocacy with the insurance sector and the GOI (Government of India). Connect has initiated dialogue with other public and private insurance companies to look at community based insurance products as well as removal of HIV as an exclusion criteria in the existing insurance products.

3. Develop models for the prevention of mother to child transmission of HIV/AIDS (PMTCT) in the private medical sector
More than 8,900 pregnant women have been counseled and tested at three PMTCT centers at private sector hospitals in Bangalore, Visakhapatnam (Vizag) and Chennai. Of the total tested, around 360 HIV positive pregnant women are enrolled for the complete package of PMTCT services and more than 250 babies have been delivered till date. Of these, 171 babies have been tested using the DNA PCR tests, and 166 babies have tested negative (transmission rate of 2.9%). The Vizag PMTCT centre has been recognized by Andhra Pradesh State AIDS Control Society (APSACS) as collaboration with the private sector. APSACS has further invited Connect to provide technical assistance (TA) to set-up 10 additional PMTCT Centers in two districts of Coastal Andra Pradesh.

4. Build sustainable corporate partnerships and mobilize resources from industries for the cause of HIV/AIDS and TB
Connect has mobilized over USD 1.15 million in cash and kind from over thirty corporate in India for the cause of HIV/AIDS and TB. Some prominent contributors being Apollo Tyres, Tata Power, Suzlon, Johnson & Johnson, Big FM, Roche Laboratories, Aurobindo Pharma and Jindal Steel etc.

5. Strengthen the systems for scale up and transition of successful private sector approaches in HIV/AIDS and TB programming through effective linkages with the National AIDS Control Organization (NACO), SACS, USG partners, provider networks and professional and industry associations.

More than 280 companies in the public and private sector enrolled for HIV/AIDS and TB workplace intervention programs. Over 255,000 formal employees in these companies were reached. More than 450 companies successfully adopted the HIV/AIDS and TB workplace policy and many more signed the HIV/AIDS and TB pledge. Over 500 senior management members of the enrolled companies were trained on policy development and institutional capacity building. More than 400 master trainers and 1,200 peer educators were trained under the ILO's cascading model.

SACS was provided TA for targeted interventions (TI) with migrant workers and integration of workplace intervention in their annual action plan. Similarly, national, state and district-level Chambers of Commerce, industrial associations, Garment Workers Trade Union and Department of Labor were provided TA and capacities built for implementing the workplace programs and policies.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	56,500
Water	3,500

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Child Survival Activities
Mobile Population
Safe Motherhood
TB
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	**9863**		
Mechanism Name:	**Connect (PSI)**		
Prime Partner Name:	**Population Services International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HVCT	410,000	

Narrative:

SUMMARY

Connect currently operates five static and six mobile HIV counseling & testing (CT) centers – called Saadhan Clinics across project locations. The clinics are mainly targeted towards core groups such as female sex workers (FSWs), intravenous drug users (IDUs), men who have sex with men (MSM) and bridge population clients such as truckers, migrants and other at-risk groups, e.g., pregnant women, TB patients and spouses of clients having high risk behavior. The CT services are client-initiated and voluntary in nature. Up until July 2009, 'Saadhan' CT clinics have counseled and tested over 62,814 clients. The prevalence rate of those testing at Saadhan clinics is approximately 6% since their inception, which indicates that the services are successfully targeting populations at significantly greater risk than the overall population. Connect CT sites focuses on providing high quality counseling and testing as per the guidelines provided by Government of India (GOI) in the most anonymous and confidential manner. Connect emphasizes on ensuring the quality of services through regular monitoring and supervision and implementing strict quality control protocols. Connect stresses on linking the HIV positive clients to the care and treatment services and ensuring that the referred client actually avails the care and treatment services. Over 3,600 HIV positive clients have been referred to various care and support organizations. About 58% of these clients have actually utilized the care and support services.

Using FY10 funds, Connect will increase reach of its CT services to most at risk populations (MARPs) and vulnerable groups, advocate better testing methods with GOI, engaging corporate and industries to establish the public private partnership models, transition CT centers to public and private partners, document and disseminate the lessons learned from the public private partnership (PPP) models to various stakeholders.

Activity 1: Transition Connect operated CT centers to public and private partners in Most-At-Risk (MAR) sectors.

In FY08 and FY09, Connect focused on getting the Connect operated CT sites recognized by GOI as a part of National AIDS Control Program (NACP-III). All Connect operated sites are recognized by GOI.

Connect leveraged support of test kits, quality assurance and training of counselors and medical technicians from GOI for its CT sites. Three Connect operated CT centers are supported by the private sector companies and corporate, under a public private partnership (PPP) as per the office of the Global AIDS Coordinator (OGAC) guidelines. One of the Connect operated CT sites in Mumbai was adopted by TATA Power, the largest corporate body in India. Additionally, this CT site is also linked with the local GOI bodies as a part of NACP-III. This public private partnership with the private sector and the local GOI body supports the staff salary, rent, demand creation activities and other running costs from the resources provided by the corporate entity and test kits, training, quality assurance of lab from the support provided by GOI. Thus, this CT site in Mumbai is sustainable and has the necessary government support to target the core and bridge population.

Using FY10 funds, Connect will mobilize resources from private sector industries and corporate to support the other Connect sites. Connect will approach the private industries and corporate in the most at risk (MAR) sector to mobilize them to adopt the CT services. Thus, during FY10, Connect will attempt to transition all CT sites to the local GOI bodies, industries and corporate. Connect will continue to provide technical support for effective operations and quality management of these sites beyond FY10, to ensure that these sites provide high quality services to the MARPs.

Activity 2: Advocating universal rapid HIV whole blood testing within CT clinics by building capacities of new service providers including community level workers.

Worldwide, rapid HIV test kits using whole blood are used for HIV testing at CT sites. The advantage of the whole blood rapid tests against the serum tests is that the test is easier to conduct (using one to two drops of blood drawn from a finger prick as against the blood drawn from the vein puncture as in case of serum testing), waiting time for results is less (10 minutes in case of whole blood test as against the minimum of ninety minutes to one day for serum testing) and it can be administered in field settings in mobile clinics or outreach CT clinics.

Universally, it is seen that there is client drop-out at government CT sites when serum testing is used and test results are not provided the same day or within the hour. There is currently no data available at the CT sites operated by GOI on the percentage of completed CT clients receiving test results and post-test counseling.

Connect will promote the use of whole blood HIV rapid testing within GOI and its partner NGOs by demonstrating its efficacy at the locations where Connect operated CT clinics are located. The advocacy efforts will involve reaching out to local District AIDS Prevention and Control Unit (DAPCU), State level SACS and NGOs to promote use of whole blood HIV rapid testing in static, mobile and in outreach CT

sites.

Activity 3: Provide high quality CT services to core and vulnerable groups.

Connect CT services continue to reach the most at risk population such as female sex workers (FSWs), men having sex with men (MSM), injecting drug users (IDUs) and bridge population such as truckers, informal workers and migrant population. The goal is to reach out to male clients to affect behavior change by increasing safer sexual practices among those with multiple partners, particularly those who engage in high-risk behavior. Using FY10 funds, efforts will be intensified to further expand and reach out to the core population effectively.

Connect will also continue to reach out to at-risk women who are sex workers and wives of men partaking in high risk behavior like MSM, IDU and men having sex with commercial sex workers. Women now make up 35 percent of all new infections among adults in Asia, up from 17 percent in 1990, and are not addressed comprehensively by HIV programs. It is estimated that more than 90 percent of women living with HIV, acquire the virus from their husbands or from their boyfriends while in long-term relationships in Asia (UNAIDS). Since women are not empowered to seek health services, Connect CT sites will conduct 'outreach' CT camps with NGOs working with women, self help groups (SHGs) and network actively with community based organizations (CBOs) exclusively working for marginalized women population.

Thus, in FY 10, Connect will actively work with NGO partners and collaborate with local GOI bodies to actively reach out to core and vulnerable, hard-to-reach populations and serve 15,000 CT clients.

Activity 4: Document and dissemination of "Best Practices in Saadhan CT Clinics" with government stakeholders and NGOs involved in CT programs.

Connect will conduct an evaluation of its various PPP CT models through external consultants/agencies. The evaluation will focus on assessing the quality of services and the impact created by Connect CT models. Connect will document and disseminate the lessons learned from PPP models of the CT services through regional level workshops to GOI, USG partners, NGOs implementing CT services. It is expected that over 50 organizations will benefit from these dissemination sessions. PSI will share tools on how "high quality" CT services and whole blood rapid tests with same-day results can be provided to most at-risk population.

Activity 5: Leveraging resources from the private sector.

Connect will focus on leveraging resources from the corporate sector to support the CT services with an objective to make the CT services sustainable beyond FY10. Connect will motivate private industries and corporations to support on the ground activities including mobile testing centers, testing kits, STI drugs, health worker salaries, collaterals and others in a designated area or across areas. The Connect project will mobilize resources by targeting large, established companies that have foundations or corporate social responsibility (CSR) initiatives which include HIV/AIDS programming. Connect will reach out to salaried individuals/high net worth individuals through payroll/online giving programs to support its CT initiative.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	440,000	

Narrative:

SUMMARY

With FY10 funds, the focus of Connect will be to document, disseminate and advocate the Connect models for strategic information that have been established and refined over the past four years. These models were established for identifying, prioritizing and selecting the economic sectors for intervention; demonstrating impact if any of health insurance on the lives of people living with HIVAIDS (PLHIV) through a quality of life assessment (QOL) and understanding the trends and patterns of corporate funding of HIV related activities as part of their corporate social responsibility (CSR). The process of refining these models was achieved through a process of peer review. Using FY10 funds, efforts will be channeled to build capacities of personnel and organizations such as USG partners, NGOs and key government institutions working in HIV and TB and broader health sector areas such as family planning (FP) and reproductive and child health (RCH) to implement interventions or formulate policies based on Connect learning. Specifically the capacities of these organizations will be built to collect and analyze strategic information relating to identifying and prioritizing work areas and decision making for initiating interventions.

Activity 1: Advocating the methodology for identifying and prioritizing most at risk economic sectors for HIV prevention programs.

Identifying and prioritizing economic sectors for HIV/AIDS programs was one of the key challenges that Connect confronted in Karnataka when the operations began in FY06. While there were many on-going efforts in implementing HIV/AIDS workplace programs, there was limited evidence and documentation available of the selection process of enterprises for implementing HIV workplace programs in India. In the absence of a robust methodology for prioritizing the economic sector, Connect developed a methodology

to assess the risk levels of workforce to HIV infection in various economic sectors. In addition, an attempt was made to understand the structural characteristics of the sectors that decide the feasibility of a workplace program. The Karnataka most at risk (MAR) study conducted in FY07 was peer reviewed and published in an international journal. Based on the learning from Karnataka, Connect conducted a similar assessment in coastal Andhra Pradesh (AP) in FY08. Connect in FY09 will get the AP MAR study peer reviewed and published.

These methodologies evolved by Connect would be of immense help to similar organizations to replicate the same across other high prevalence regions in the country. In FY10, professionals from organizations such as USG partners, Government of India (GOI), nongovernmental organizations (NGOs) involved/interested in MAR will be trained to implement the methodology. Connect will also provide technical support to organizations in conducting MAR studies.

Activity 2: Dissemination of findings from the cohort assessment of quality of life (QOL)

Connect as part of demonstrating the impact of insurance coverage on PLHIV conducted the first wave of the QOL assessment for the cohort of PLHIV enrolled in 2008. The cohort was followed up in FY09 and will be done so in FY10 as well for the subsequent waves. Using FY10 funds, Connect will disseminate the findings from this assessment to GOI, PLHIV networks as well as insurance companies to provide strategic information on the impact and viability of insurance cover to PLHIV. Also, as the QOL study by Connect is one of the first community based QOL studies in India, it will also throw more light on the quality of life of PLHIV in the country. In FY10, Connect will facilitate documentation of the QOL assessment and facilitate the peer review for enhanced credibility. Technical support will be provided to organizations in conducting similar QOL assessments.

Activity 3: Dissemination of findings from the survey on corporate social responsibility (CSR) programs of high value companies in India.

From Connect's experience of mobilizing corporate resources in India, it was learnt that there is no readily available database on CSR programs of companies in the area of health. Segmentation of companies was difficult for marketing efforts due to paucity of data. In order to ensure focused efforts in mobilizing corporate resources in India, In FY09, Connect undertook a survey of top Indian corporations to understand the trends and patterns of social responsibility mandates and spending in India. In FY10, Connect will document and disseminate the findings from the survey, which will provide key insights of

CSR programs in India with specific focus on HIV and TB interventions. This survey and its finding will also help GOI a better understanding on how to aligning its efforts in engaging the private sector as per the mandate in National AIDS Control Program III.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	1,300,000	

Narrative:

SUMMARY

In FY10 and beyond, Connect aims to become the active partner of Government of India (GOI) for mobilizing private sector insurance companies in defining their role and contribution to the national program as per National AIDS Control Program-III (NACP-III). Connect in the previous years also partnered with state nodal agencies implementing a social security scheme for low income populations for inclusion of people living with HIV/AIDS (PLHIV). In FY07, it partnered with Karnataka Network of People Living with HIV/AIDS (KNP+) and Star Health and Allied Insurance Company in India, in refining a group health insurance product for PLHIV. Star Health had earlier forayed into this untapped area by identifying it as a potential area of growth, given the lack of any other player in this field. Connects efforts in FY08 and FY09 were focused on sensitizing and mobilizing PLHIV networks/nongovernmental organizations (NGOs)/insurance companies and USG Partners for the provision of health insurance for PLHIV and demand creation for the products/schemes available. Efforts were also made to mobilize other private and public sector insurance companies to develop competitive products encompassing the needs of PLHIV. Using FY10 funds, Connect will focus on three major activities. First, Connect will transition the systems developed to mobilize and manage insured groups to PLHIV networks and other key stakeholders. Second, lessons learned from the experiences on mobilization and increased engagement of insurance sector to mitigate HIV/AIDS will be used to provide technical support to GOI and other relevant institutions to evolve viable health financing solutions for PLHIV in the country. Thirdly, Connect will use various regional, national and international platforms to disseminate the lessons learnt. Connect beyond FY10, will provide technical assistance (TA) to key stakeholders in enhancing their competencies in mobilization and managing health insurance for PLHIV as well as advocate for policy change and leverage private sector resources for marginalized PLHIV segments, such as widows and orphans.

Connect will also engage with key stakeholders in mainstreaming HIV/AIDS and TB in their existing programs for formal sector workforce. Connect will continue leveraging resources from individuals, private and public sector corporate to ensure long term sustainability of HIV/AIDS and TB programs.

Activity 1: Providing TA and building capacity of positive networks, NGOs, GOI programs as well as other organizations and to mobilize manage and scale up PLHIV insurance schemes

With the experience of facilitating a pilot insurance policy in India and the lessons learned in monitoring it over the past years, Connect using FY10 funds will continue to focus on building the capacities of the Indian Network for People Living with HIV/AIDS (INP+), regional networks and NGOs to independently mobilize, and manage insured groups. Capacities of the identified organizations will also be built in exploring health financing mechanisms for PLHIV insurance in partnership with micro-finance institutions and self-help groups. The key areas of focus for capacity building will be assessing the health needs of PLHIV, advocating with hospitals and insurance companies to provide quality services, sensitizing the insured on claim procedures and streamlining settlement processes. With the goal of supporting convergence of HIV care and support programs with existing government health and nutrition schemes, Connect will sensitize national and state government associations and NGOs working in reproductive and child health programs on the insurance model for PLHIV. It is expected that through such capacity building, the respective organizations are empowered to take direct interventions to mobilize and manage insured groups forward beyond FY10, with continued technical support from Connect.

In FY09, Connect identified and networked with GOI's social security scheme 'Rashtriya Swastha Beema Yojna' (RSBY) to extend insurance cover to low income PLHIV. Using FY10 funds, Connect will build the capacity of NGOs/CBOs in scaling up PLHIV enrollments and utilization of services under the scheme. This is an important step in building social inclusion of PLHIV, thereby reducing stigma and discrimination.

Activity 2: Transitioning of the sustainable models for financing PLHIV insurance schemes to PLHIV networks/NGOs/CBOs/other agencies

Affordability of the current insurance product has proved to be the biggest barrier to rapid scale up. The problem is further aggravated as the entire premium has to be paid as a single installment. In FY09, Connect worked on making the current insurance product/s, affordable to low income PLHIV segments by creating linkages with microfinance institutions to reduce the barrier regarding ability to pay. These learning's were documented and using FY10 funds will be disseminated to PLHIV networks/NGOs/CBOs who have been trained for mobilizing PLHIV for health insurance. This will greatly reduce the barriers on the ability to pay one time premiums for the current health products.

Activity 3: Advocate for removal of HIV/AIDS exclusion in general health policies with insurance companies and government agencies

HIV infection is an exclusion in most of the generic insurance products. With FY10 funds, Connect will continue to advocate with the insurance providers as well as policy makers for the removal of this exclusion. Connect with the evidence and experience gained through the pilot efforts in providing insurance for PLHIV will influence GOI to advocate for inclusion of PLHIV with community risk pooling and health insurance mechanisms, such as RSBY planned under the government health initiatives. Connect will also advocate along with GOI institutions in the regions/states to ensure that insurance agencies contracted to provide health insurance for poor by the respective regional institutions, do not exclude PLHIV.

Activity 4: Evaluation of the health insurance products and services/micro insurance schemes and systems established to mobilize and manage insured PLHIV groups

In FY09, Connect continued to promote the insurance products and micro insurance schemes available for PLHIV across the USG priority states in India. In FY09, Connect also developed and put in place systems to mobilize and manage insured groups of PLHIV. In FY10, various insurance products/systems for mobilizing and managing insured groups facilitated by Connect will be subjected to expert evaluations to understand how sensitive they are in catering to the needs of PLHIV in India and the viability of replication across the country.

Activity 5: Dissemination of models and lessons learned to Government agencies, other USG Partners, NGOs, Positive Networks and Insurance Providers

In FY10, Connect with technical experts will conduct evaluations, secondary analyses and documentation of health insurance and microfinance models for PLHIV. Connect learning on insurance efforts will be distilled to publications for the benefit of key stakeholders. This will act as a knowledge repository. Dissemination will also address the Ministries of Health & Family Welfare, Ministry of Labor, and Poverty Alleviation, IRDA and Women & Child Development and private sector players. Dissemination will be done through advocacy events, consultations, exposure visits, and conferences on Health Insurance for PLHIV (example FICCI/CII Conference).

Activity 6: Capacity building of government organizations, industry associations, sector specific stakeholders and NGOs for mainstreaming HIV and TB interventions within their sectors

Using FY10 funds, Connect will focus on providing TA to government departments such as the Department of Labor in mainstreaming HIV and TB interventions within their agenda. Connects support to relevant departments to integrate HIV and TB awareness education program in their existing programs will be transitioned to the mainstreaming component of State AIDS Control Societies in Andhra Pradesh

and Karnataka.
FICCI and other employer's organizations in Karnataka and Andhra Pradesh will be encouraged to motivate its member companies to include HIV/AIDS and TB in their induction trainings and human resource policies.

In FY 09, different workplace models implemented under Connect will be evaluated internally as well as by external experts to find out the feasibility of replication. In FY 10, Connect will engage with GOI and other identified stakeholders to build their capacities on replicating the successful models. Connect will provide technical assistance to GOI, industry associations, sector specific stakeholders and NGOs in replicating the successful model with different groups at different locations.

Activity 7: Leveraging resources from the private sector

Using FY10 funds, Connect will partner with corporations towards establishing a corpus for a National Trust for HIV&AIDS in collaboration with the GOI. This trust will have a pool of funds available for the purpose of initially supporting the cost of insurance premiums for PLHIV such as orphans and widows, establishing, running and maintenance of all HIV and AIDS related programming efforts including PMTCT, counseling and testing, work place interventions and systems strengthening of organizations working on the issue of HIV and AIDS. Connect will also mobilize resources from high net worth individuals, private and public sector employees for HIV/AIDS and TB activities. Corporations will be motivated to support innovative programs which serve to address the brand building efforts of the corporate through CSR programs. Connect will work closely with its partners like FICCI, KCCI and other NGOs/CBO's to ensure capacity building on resource mobilization with a view to ensure sustainability of their programs through successful resource mobilization.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	250,000	

Narrative:

SUMMARY

Since FY06, Connect has reached over 250,000 workers across its project locations with messages of sexual abstinence, partner reduction and monogamy (A-B). Most of these contacts were achieved in the initial two years of the project when the PEPFAR focus was more on A-B. In FY07, following a shift in PEPFAR focus from A-B to other prevention, it was decided to scale down the number of individuals reached for A-B messages. Consequently, the number of individuals to be reached in FY08 and FY09 with A-B messages was scaled down to over 20,000. Using FY10 funds, Connect will continue to reach

over 20,000 formal workers with the message of A-B through its workplace intervention programs.

Activity 1: Reaching formal sector workforce with A-B messages

In FY10, Connect will continue to reach out to the formal workers at their workplace through its workplace intervention program with messages on A-B. The workers will either be reached on one to one or in small group sessions. The messages of abstinence, being faithful, partner reduction and monogamy will be disseminated through the training sessions held for the workers. Workplace communication materials like posters, leaflets and pamphlets, based on triggers and barriers to adopting abstinence and being faithful will be developed for workers in the industrial sector who are vulnerable to high-risk behaviors. 'Master' trainers and peer educators will be trained to promote A - B messages and to foster social norms that promote risk reduction. Also, to increase senior management commitment for the cause, Connect will reach out to private sector companies to commemorate World AIDS Day.

Activity 2: Transitioning of Connect models to industrial organizations and NGOs

In FY09, Connect built the capacities of NGOs and industrial organizations in designing, implementing and monitoring of Connect models of reaching out to formal workers. Using FY10 funds, Connect will direct efforts to transition its models for reaching out to the formal workforce to these NGOs and industrial organizations. Efforts will be made to transition the overall management and knowledge of the program implementation, tools, materials and training modules for training the outreach workers for effective communication, monitoring and evaluation of the program.

Activity 3: Advocacy for scaling up program model for reaching Women in the Workforce Vulnerable to HIV/AIDS

In FY09, Connect implemented an intensive behavior change communications plan to reach out to women in the garment sector with messages promoting negotiation skills, improved health seeking behavior pertaining to reproductive health, HIV/AIDS and TB. Connect actively promoted increased use of preventive products and services; worked for increasing demand with voucher based schemes and on the ground communication activities. To improve access to services, the existing services in the public and private sector were mapped and linkages were established. Using FY10 funds, Connect will engage with local NGOs/garment workers union to implement the model established over the last year. This will involve identifying the right partner, mapping its competencies, capacity building for effective replication of the Connect model. To enable smooth transition, Connect will continue to provide technical support to the implementing organization on an ongoing basis. The learning of two years wherein Connect established a workable model of engaging with a most at risk economic sector and the transition to a

local NGO/ workers union and successfully overseeing it will be documented and disseminated as a case study for advocating as workable model in other economic sectors where women comprise a majority of the workforce.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	950,000	

Narrative:

SUMMARY

Capitalizing on its experience of reaching the workers in the most at risk economic sectors, Connect will position itself as a key player in the area of interventions for most at risk workers. Since FY06, Connect has reached to more than 500,000 individuals with messages of other sexual prevention focusing on condom use. In FY07, Connect assessed the risk level of economic sectors for prioritizing the workplace intervention program in Karnataka. Construction, garment, fishing, mining and sugarcane were identified as most at risk economic sectors. Subsequently, Connect commenced behavior change communication activities in these sectors. In FY09, Connect transitioned its communication activities in the most at risk economic sectors of Karnataka to other organizations (nongovernmental organizations (NGOs) and sectoral trade unions) and measured the change in behavior. In the same year, based on the findings of the Andhra Pradesh most at risk assessment, Connect initiated behavior change communication activities in the identified economic sectors of coastal Andhra Pradesh. Using FY10 funds, Connect will focus on measuring the change in behavior amongst the most at risk workers in the economic sectors of Andhra Pradesh, transition its activities and assume a role of technical assistance (TA) provider. Connect will document and disseminate its learning and best practices based on its experiences in Karnataka and Andhra Pradesh.

Activity 1: Demonstrate impact of interventions in most at risk workers in Andhra Pradesh.

In FY09, Connect focused on demonstrating and documenting the outcomes from interventions through Behavior Change Impact Studies (BCIS) in the economic sectors of Karnataka. The BCIS measured changes brought about in behaviors among the target population due to project activities. In FY10, Connect will conduct similar BCIS in the economic sectors in Andhra Pradesh. Over 380,000 workers will be reached with 'condoms and other prevention' messages and over 20,000 workers will be reached through 'being faithful' messages.

Activity 2: Transitioning Connect models to government, NGOs and private sector organizations.

Under the mandate of the project, Connect in its final year will attempt to transition successful models of reaching out to most at risk populations. Using FY10 funds, Connect will focus on an external evaluation of the models created over the last two years. Basis the learning from the external evaluation, Connect will execute the transition of the successful model to community-based organizations (CBO) including sector specific associations/identified NGOs/government/private sector. Connect will build the capacities of identified organizations on effective management of programs across all levels including better targeting efficiency, social marketing of products and services, better monitoring and evaluation processes and tools for behavior change communication. The capacity- building plan will include training people on improving awareness on condom usage and tailoring messages related to condom use across various target populations in the most at risk economic sectors. Relying on Connect's lessons on building corporate partnerships, the identified organizations will be trained to raise resources for sustaining the programs.

Activity 3: TA to Government of India (GOI) and other private organizations.

Gaining from its experience in reaching out to the most at risk economic sectors, Connect will provide TA to GOI and other private organizations for implementation and scale up of the models. Connect will provide TA for identifying the most at risk economic sector, prioritizing the sectors for interventions and establishing the intervention models. Connect will also provide TA on development of communication tools and materials, training of the outreach workers for effective communication and monitoring and evaluation of the intervention.

Activity 4: Documentation and dissemination of best practices.

In FY10, the focus of Connect will be to document and disseminate the Connect models of reaching workers in the most at risk economic sectors. Based on an external evaluation of its intervention models the best practices will be identified. Connect will document the reasons for the success and failure of different models of reaching to MARPs with messages on other sexual prevention (consistent condom usage), lessons learned and challenges faced. The learning will be disseminated utilizing the available strategic platforms. Connect will organize national dissemination programs exclusively for this purpose. Working papers and articles based on Connect's experience will be presented at various international and national conferences to highlight models. Documents will be published in national and international journals and made available to stakeholders such as GOI, employer's organizations and other key stakeholders for wider dissemination. All publications will be made available in electronic versions as well as in hard copy.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	MTCT	550,000	

Narrative:

SUMMARY

In FY08 and FY09, Connect established three PMTCT centers in the private medical sector, conducted an external assessment of its three centers and demonstrated impact. With FY10 funds, Connect will aim to become a technical assistance (TA) partner to the Government of India (GOI), United Nations Children Emergency Fund (UNICEF) and other PMTCT implementers in India. In FY10, Connect will focus on four major activities. First, Connect will transition the direct implementation of three PMTCT centers to the partner hospitals and will continue to provide TA. Second, Connect will provide TA to state AIDS Control Societies (SACS) and Federation of Obstetrics and Gynecologists Societies of India (FOGSI) for increasing private sector involvement in PMTCT. Connect will further engage the private sector hospitals through associations of private hospitals and nursing homes to motivate them to replicate the Connect PMTCT models. Third, Connect will try to influence other national PMTCT programs to replicate the best practices of Connect as identified through the external evaluation. Additionally, Connect will continue developing a knowledge bank on private sector PMTCT by documenting and disseminating lessons learned from implementing the Connect model.

ACTIVITY 1: Transition the Connect PMTCT "centers of learning" to partner hospitals.

In FY09, the Government of India (GOI) recognized the three Connect PMTCT centers under their public private partnership program. Under this program, Connect continued to leverage resources such as test kits, safe delivery kits, training and quality assurance for labs from the SACS. In FY10, Connect will focus on transitioning the service delivery components such as counseling, data maintenance and monitoring of PMTCT sites to the private partner hospitals. Connect will build capacities of the identified hospital staff in providing quality counseling and will link the PMTCT activities in overall hospital management systems.

Connect will build the capacities of local nongovernmental organizations (NGOs) and Community Based Organizations (CBOs) in demand creation of PMTCT centers and case management approach to follow-up the infected mothers and their infants. Connect team will build the capacities of the Community Advisory Board (CAB) to raise resources at the local level to support the PMTCT activities. Additionally, Connect will link the three centers of learning with other government programs such as National Rural and Urban Health Mission (NRHM and NUHM, particularly the Family Planning and Reproductive and Child Health programs), Revised National Tuberculosis Control Program (RNTCP), Orphan and Vulnerable Children (OVC) programs, Integrated Child Development Scheme (ICDS for leveraging nutritional supplements) for leveraging resources and better integration of PMTCT services with the

health programs.

By the first quarter of FY10, Connect will transition its role from direct implementation and will continue to provide TA to the three sites to provide quality PMTCT services.

ACTIVITY 2: Influencing national PMTCT program to replicate the best practices implemented in private sector PMTCT.

In FY09, Connect collaborated with various key stakeholders to evaluate the private sector PMTCT programs in India and documented the best practices through a compendium. Connect conducted one national and two state level workshops to disseminate the outputs from the assessment. Using FY10 funds, Connect will make efforts to influence PMTCT implementers like GOI and UNICEF to adopt the best practices identified through the assessment in the national PMTCT program. Connect therefore, will work closely with the technical resource group (TRG) of national AIDS program for influencing national policy and guidelines on PMTCT. Connect in close conjunction with UNICEF and other key PMTCT players in the private medical sector will organize seminars and workshops highlighting the best practices in private sector that are cost effective and replicable in national program.

ACTIVITY 3: TA to GOI for expansion of public private partnership models for PMTCT integrated counseling and testing center (ICTC) services in private health sector.

In FY08, Connect initiated technical assistance (TA) to APSACS (Andhra Pradesh State AIDS Control Society) for expansion of PMTCT in private sector hospitals. As part of this collaboration, Connect partnered with APSACS to set up 10 additional PMTCT centers in the private sector in the districts of Vizag and Srikakulam of coastal Andra Pradesh (six, including existing Connect center in Vizag and four in Srikakulam district). Connect provided TA for identifying and mobilizing private hospitals for establishing the PMTCT services and monitoring the centers' activities. SACS provided test kits, safe delivery kits and training for PMTCT. The private hospital contributed the infrastructure and human resources for implementing the PMTCT services. In FY09 and FY10, Connect will provide TA to at least two other SACS (Karnataka and Maharashtra) in high prevalence states for setting up public private partnership models for PMTCT in the private sector along the lines of the centers in Andhra Pradesh.

ACTIVITY 4: Increasing private sector involvement in PMTCT through associations of private practitioners, nursing homes and corporate hospitals.

In FY09, Connect team initiated the process of engaging FOGSI for mobilizing private medical sector to establish PMTCT centers. In partnership with FOGSI, Connect conducted a mapping of the obstetricians

and gynecologists in the program areas. Based on pre-determined selection criteria, Connect selected the private health facilities for establishing PMTCT centers in the private medical sector. Having selected the private medical facilities, Connect focused on providing intensive training to the designated staff of the hospitals on the various aspects (screening, counseling, safe delivery and case management) of PMTCT. Using FY10 funds, Connect will continue to provide TA and technical support visits to the private hospitals to monitor the various aspects, such as providing quality counseling, testing, and clinical care to HIV positive pregnant women and follow up of mother and baby pairs, on which training was provided to the health facilities.

Based on its experiences with FOGSI and the private healthcare providers, Connect in FY10, will identify and mobilize the private hospitals and medical institutions run by the corporate bodies and motivate them to establish and implement PMTCT services. Connect will evaluate and determine the cost effective business model of PMTCT services which would be attractive to the private hospitals. Connect will engage the private hospitals through meetings/conferences to disseminate the cost effective business model. Connect will provide TA for initiating the PMTCT services along the same lines as the other private health care providers. Using FY10 funds, Connect envisages mobilizing at least two corporate hospital bodies to establish PMTCT services.

ACTIVITY 5: Develop a knowledge bank for private sector PMTCT services.

Using FY10 funds, Connect will develop a knowledge bank for the private sector PMTCT. Connect team will come up with manuals and working papers on establishing, implementing and monitoring of PMTCT programs in the private medical sector. The key manuals are: a manual on a step by step approach for engaging private sector hospitals, establishing and implementing PMTCT services.

Connect will also develop and disseminate manuals for conducting stigma and discrimination workshops that can serve as tools for GOI and other implementing agencies to implement the stigma reduction programs in health care facilities. In addition, Connect will focus on publishing peer-reviewed articles on private sector PMTCT models in national and international journals to disseminate the lessons learned from Connect sites.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10085	**Mechanism Name: SHARE**

Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Share Mediciti (Umbrella)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 700,000	
Funding Source	**Funding Amount**
GHCS (State)	700,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

PHMI is a non-profit organization established in 2006, with a mission to improve quality of life through organizational capacity building and enhancing individual capacities of public health (PH) professionals. The goal of PHMI is to build human and organizational capacities improving systems for SI management, evidence based decision making, data based planning and program implementation by introducing scientific systems of needs identifications, assessments, trainings, building human capacities and addressing organizational challenges. The current focus of PHMI is on HIV/AIDS programs and related activities in Andhra Pradesh through PH trainings, providing consultants (India, AP and District), adopting scientific approaches for program planning, designing and implementation that emphasize the quality and standardization of healthcare delivery.

Objectives of PHMI:
1. To develop competency of PH workforce with special focus on HIV through:
i. The Public Health Field Leader Fellowship (PHFLF) program at State level, through the District AIDS and Prevention Control Unit's (DAPCU) capacity building initiatives at district level and the Data for Decision Making (DDM) training program for both the public and private. sector
ii. Short term trainings on Management, Communication, Advocacy, DDM, etc for district and state level managers
iii. Conducting continuing medical education and workshops encouraging the sharing of experiences and mainstreaming HIV interventions
iv. Creation of a virtual platform for information and knowledge-sharing among faculty, fellows and trainees

v. South to South collaboration: Provide assistance to state and national level PH workforce to gain knowledge from international field experience
2. Systems and policy strengthening by providing consultancy, manpower and TA to:
i. Local institutions such as Andhra Pradesh State AIDS Control Society (APSACS) and National Rural Health Mission (NRHM)
a. by placing technical experts as consultants for specific components under NACP III
b. by directly giving TA on various program components, activities or campaigns, data management, and analyses and dissemination in the context of program priorities
c. by assisting with quality documentation and reporting work
ii. NGOs (both USG and non-USG Partners) in AP and other areas in India

Key Ongoing Activities:
• System strengthening through TA by providing domain experts as consultants for strategic and evidence-based planning and implementation, as a support to APSACS and other developmental partners in AP, specifically:
• Consultants for (i) Surveillance, Monitoring and Evaluation (ii) Integrated Counseling and Testing Centre and (iii) DAPCU and NRHM Convergence programs
• Developmental partners and Local NGOs are trained for implementing HIV programmes as per NACP guidelines through direct human capacity development. Domain Experts from developmental partners were also called for these trainings
• Building human capacities of individuals and organizations for quality and standardized implementation of the NACP III program adapting scientific tools and instructional design-based approaches with National and State priorities. Activities under this include:
• Capacity building of DAPCU staff: On the basis of scientific training needs assessment by PHMI, APSACS developed a strategy for capacity building of DAPCU staff in five different phases
• A DDM Program based on international experience to provide both State and District level PH professionals with ongoing "in-service" technical training and mentoring assistance to use information and data for effective planning and program implementation
• Short term trainings for various PH personnel and NGO stakeholders for effective program planning, management and implementation e.g. Epi-Info, Excel, Data management, TI program management, Program Management (PM) and DDM
• Provide TA and trainings to support APSACS program managers in developing evidence-based decentralized action plans at the district level for implementation of HIV/AIDS services
• South to South collaboration to facilitate various stakeholders' sharing of programmatic experiences in larger national and international forums and also towards providing opportunities for capacity building of said stakeholders
• Develop a virtual and open source Learning Management System and web portal to share and

disseminate various resources developed as well as a Public Health Human Resource Directory for AP to set up Human Resource Information systems within the State, as a model for larger replication.

Project Achievements and Innovations:
• Continue to assist 3 consultants at APSACS providing technical support in program planning and implementation in areas of Surveillance/M and E, ICTC and DAPCU/ NRHM convergence.
• Facilitated and provided TA to APSACS in decentralized evidence-based District Action Planning exercize with participation from approximately 1,400 HIV program staff representing 600 organizations, who are developing an evidence based State annual action plan for 2009-10.
• Built capacity of all 23 districts' Additional District Medical and Health Officers (ADMHOs) in AP, and another 50 participants (Field Expert Group) for developing an evidence-based decentralized action plan.
• Assisted APSACS in recruiting 69 DAPCU staff (1 per district), including District Programme Managers, M and E assistant and Accounts assistant.
• Undertook orientation and induction training of all 69 DAPCU staff.
• As a part of APSACS capacity building strategy, trained 22 DPM on NACO- Targeted Interventions (TI), STI components and 23 M and E assistants on NACO- Basic Services Division (BSD), Blood Safety (BS), Computerised Management Information System (CMIS) and Monitoring and Evaluation
• Trained 89 participants from 64 TI NGOs on PM and 48 participants from various organisations on Epi-Info and Excel.
• Initiated and completed one year PHFLF program with a batch of 25 PH professionals; Internal and Mid-term Reviews have also been carried out.
• Provided TA for an integrated approach services mapping; training given to 65 outreach workers in one district of AP
• Organized a media sensitization workshop for journalists focused on interpretation of essential HIV/AIDS information in India and AP.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	10085		
Mechanism Name:	SHARE		
Prime Partner Name:	Share Mediciti (Umbrella)		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	HVSI	200,000	

Narrative:

SUMMARY

The National Program in India, under NACP-III, is increasingly prioritizing the use of data and information for program planning and designing. It is generating quality, reliable and complete programmatic data and feeding it back into the program to influence field level decisions. By doing so, effective evidence-based program planning, design, implementation, review and monitoring is seen as a key thrust area by Government of India (GOI) at the national and state levels.

SI support is continually a component of PHMI's efforts to strengthen National HIV program management at the national level and in USG priority states e.g. Andhra Pradesh (AP), Tamil Nadu (TN), Orissa, North-East (NE), among others. The activities are aimed at strengthening National Data and information management systems through various mechanisms; placing technical consultants for SI, conducting a review of existing HMIS, planning for redistribution of human resources and logistics, disseminating scientific information and latest updates on HIV/AIDS, building the capacity of the state and district-level staff from government and non-government sectors on data and information management. The following activities describe specifically the FY10 plan of PHMI:

Activity 1: TA/Consultancy to NACO, NERO & SACS (in AP, TN, Karnataka, NE states) and collaborative support with non-HIV stakeholders within the Government or NGOs

PHMI has a rich experience of providing direct TA at different levels, for different program priorities that include assistance for NRL and SRL assessment, scale-up of Link ART Center in AP; support to FEG in AP; preparation of District and Annual Action Plan (DAP & AAP); ongoing TA for data triangulation and epidemiological profiling at district level; assistance in scale-up of the private sector ICTC; piloting of lab certification in public sector; assistance for SHUBHAM in AP documentation, etc. In addition to those above, PHMI will continue to provide TA to various aspects of system strengthening like convergence of the National HIV program with NRHM; smooth functioning of supply chain system; data triangulation from surveillance, NFHS, routine program data and other sources, standardized scale up of ICTCs in private hospitals; quality assurance in Link ART Centers (LAC); private sector scale-up of care and treatment

services; system for quality assurance for HIV testing; quality data management system particularly for surveillance; scientific and programmatic documentation / publication; HCD systems within the National program; building interest and providing support in evidence-based program planning and implementation for SACS and DAPCU staff etc.

Share India PHMI will explore areas of convergence and integration with existing non-HIV public health programs by collaborating with Government and developmental partners including WHO, ICMR, NIE, PHFI. Specific TA would be provided such as development of an effective mentorship program to guide and direct professional working in the field; Collaborating with organization like ICMR and facilitating the application of research knowledge and theories in to practical real life settings; Providing managerial skills training to public health professionals in order to strengthen their team building leadership, interpersonal, effective communication skills and program management competencies.

By collaborating with the leading institutions and agencies listed above, it would be practical to then draw on the expertise and valuable inputs of these institutions and staff, which will help in empowering the professionals working in the program technically, managerially and programmatically.

Activity 2: Consultants & Experts as staff for TA to and at NACO, NERO & SACS (in AP, TN, Orissa, NE States)

SHARE India PHMI, in consultations with CDC and NACO, will utilize additional staff as consultants and technical experts to provide programmatic and technical assistance, which will focus on convergence of core areas of national HIV/AIDS program such as: RTI/STI management; Condom Promotion; VCT; PPTCT; BCC; Blood Safety; Training; and HIV data/Information Management Systems in to NRHM, HCD trainings, strategic information, supply chain management to forecast for HIV drugs, laboratory reagents, equipments and commodities ensuring overall compliance with corporate assets management, HIV testing quality assurance in ICTCs, ART program quality assurance, Centers of Excellence and others.

The role of these consultants will be to provide TA to programs and their staff, in terms of strengthening program design, planning, implementation, review, monitoring and supervision. The broader goal will be to establish sustainable systems with adherence to national guidelines and build in-house capacities of the host government and program staff through mentoring, on-the-job training assistance and supportive supervision.

Activity 3: Public Health Fellowship on HIV/Public Health Management

Public Health Field Leaders Fellowship (PHFLF) deals with the science, skills and practices of public

health for mid-career professionals working in the field of HIV program planning, monitoring and implementation. The program will be conducted in collaboration with PHFI. It is a one year on-the-job training program with six contact weeks (following a particular theme such as project management, communication and advocacy, prevention and behavior change, Continuum of Care, community assessments, science-based interventions design, and evidence-based planning) with distance learning assignments and background reading material. To maximize synergy of the contact courses, Fellows will be assigned an advisor who will serve as a mentor throughout the entire course of study.

This program adopts its training culture from CDC-FETP and DDM program. During the course of this funding, alternate ways of conducting FETP program for non-government sector with exchange of technical resources and innovative costing mechanisms will be identified. The objective is to expand the reach of this high quality training beyond public sector because Public Health programs as well as health care seeking practices in India are now occurring largely in non-public health sector.

Activity 4: Training on DDM for District and State level staff

Competent staff is important for NACP III's strategic thrust on evidence-based program planning in a decentralized setting. Using data for making decisions is important for program managers in meticulous planning and decision making for current programs based on available data. SHARE India will conduct training programs on Data for Decision Making (DDM) for district and state level staff from the government and non-government sector. The curriculum will be developed after scientifically assessing participant's needs. Major curriculum areas include development of skills on project management, community assessment, science-based interventions design, and evidence-based planning.

This primary focus of the DDM on-the-job trainings rests on five core areas: advanced concepts of planning/formulation of District Action Plan (DAP), implementation of DAP, supportive supervision, communication, advocacy and program management. Faculty, trainers and trainees will be supported by web-based distance learning modules and an online repository of documents.

Activity 5: Technical assistance to Districts for District Level Program Management

Based on the success of Field Experts Group (FEG), a concept during development of state and district level action plans for 2009-2010, with APSACS, PHMI envisages giving continuity to the FEGs with a redefined role of providing TA to the Districts and new district- level staff to implement, manage, review, monitor and supervise the programs. Accordingly, PHMI will undertake the following specific activities:
a) Strengthening of FEGs- to focus on implementation of NACP III at district-level who will play an important role in mentorship and supportive supervision of DAPCU staff. The group of experts will be

brought in on a voluntary basis to support DAPCU.
b) Mentors training and Periodic workshops- Training of Trainers (ToT) and refresher trainings will be conducted for FEGs to refine their approach towards field mentoring exercise. PHMI will sponsor FEGs for various trainings, workshops or seminars for new ideas and capacity building, based on their performance and rapport with district staff.
Activity 6: Technical Workshops for disseminating and sharing information on HIV, Health and Public Health science:
The main objective of technical workshops is to disseminate data, evaluation reports and best practices on HIV/AIDS-related information to understand public health status in AP, TN, NE states and Orissa.

The target group includes state health department officers, NRHM and APSACS officials, DAPCU team, public health experts, field level coordinators, district level program officers, health and management institutional heads, training officers of government, non- governmental institutions working in Health sector and the state and district level positive network representatives.

PHMI will organize two such workshops in the year 2010-2011. These workshops will be conducted in collaboration with various public health academic, training and research institutions like IIPH, ASCI, HIS and leading universities such as Osmania and Pune. PHMI will undertake two dissemination workshops to share the findings of processes, output, outcome evaluation reports and best practice learning documents.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	500,000	

Narrative:

SUMMARY

Share India under this grant has the mandate and a major goal of building organizational strengths through capacity building of program staff, managers, and to provide technical support and information sharing. Developing robust, sustainable systems and sound manpower to manage them is essential and PHMI will focus on activities to address the two. Creating platforms for mutual sharing of information and ideas is an important task in this sector. PHMI through the activities listed below, aims to achieve the above stated broader goal of building organizational, as well as human capacity for strengthening systems for HIV programming in AP and beyond.

Activity 1: TA/Consultancy to NACO, NERO & SACS (in AP, Tamil Nadu, Karnataka, North East states) and collaborative support with non-HIV stakeholders within the Host Government or NGOs

PHMI has a rich experience of providing direct TA at different levels, for different program priorities: Assistance for NRL and SRL assessment; Scale up of Link ART Center in AP; support to FEG in AP; preparation of District and Annual Action Plan (DAP and AAP); ongoing TA for data triangulation and epidemiological profiling at district level; assistance in scale-up of private sector ICTC; Piloting of Lab certification in public sector; and assistance for SHUBHAM in AP documentation. In addition to above, PHMI will continue to provide TA to various aspects of system strengthening: convergence of the national HIV program with NRHM (by collaborating with the host government and developmental partners including WHO, ICMR, NIE, PHFI); smooth functioning of supply chain system; data triangulation from surveillance, NFHS, routine program data and other sources, standardized scale up of ICTCs in private hospitals; quality assurance in Link ART Centers (LAC) ; private-sector scale up of care and treatment services; system for quality assurance for HIV testing; quality data management system particularly for surveillance; scientific and programmatic documentation/publication; HCD systems within the national program; building interest and providing support in evidence-based program planning and implementation for SACS and DAPCU staff etc.

Specific TA would be provided in arenas such as, development of an effective mentorship program; collaboration with organizations like ICMR, and facilitation of the application of research knowledge and theories in to practical real life settings; providing managerial skills training to public health professionals in order to strengthen their team building leadership, interpersonal, effective communication skills and program management competencies.

Activity 2: Consultants & Experts as staff for Technical Assistance to and at NACO, NERO & SACS (in AP, Tamil Nadu, Orissa, North eastern States)

SHARE India PHMI, through consultations with CDC and NACO, will place additional staff as consultants and technical experts to provide programmatic and technical assistance, which will focus on convergence of core areas of National HIV/AIDS program like RTI/STI management, Condom Promotion, VCT, PPTCT, BCC, Blood Safety, Training, and HIV data/Information Management Systems in to NRHM, HCD trainings, SI, Supply chain management to forecast for HIV drugs, laboratory reagents, equipments and commodities ensuring overall compliance with corporate assets management, HIV testing quality assurance in ICTCs, ART program quality assurance, and Centers of Excellence.

The role of these consultants will be to provide TA to the program and its staff in terms of strengthening program design, planning, implementation, review, monitoring and supervision. The broader goal will be to establish sustainable systems with adherence to national guidelines and build in-house capacities of the host government and program staff through mentoring, on-the-job training assistance and supportive

supervision.

Activity 3: Public Health Fellowship on HIV Management

Public Health Field Leaders Fellowship (PHFLF) deals with the science, skills and practices of public health for mid-career professionals working in the field of HIV program planning, monitoring and implementation. The program will be conducted in collaboration with PHFI. It is a one year on-the-job training program with six contact weeks (following a particular theme such as project management, communication and advocacy, prevention and behavior change, Continuum of Care, community assessments, science-based interventions design, and evidence-based planning) with distance learning assignments and background reading material. To maximize synergy of the contact courses, fellows will be assigned an advisor who will serve as a mentor throughout the entire course of study.

During the course of this funding, alternate ways of conducting FETP program for the non-government sector with exchange of technical resources and innovative costing mechanisms will be identified. The objective is to expand the reach of this high quality training to beyond public sector because public health programs, as well as health care seeking practices, in India are now occurring largely in non-public health sector.

Activity 4: Training on DDM for District and State level staff

Competent staff is needed for NACP III's strategic thrust on evidence-based program planning in a decentralized setting. Using data for making decisions is important for program managers in meticulous planning and making decisions for current programs based on available data. SHARE India will conduct training programs on Data for Decision Making (DDM) for district and state level staff from government and non-government sector. The curriculum will be developed after scientifically assessing participant's needs. Major curriculum areas include development of skills on project management, community assessment, science-based interventions design, and evidence-based planning.

This primary focus of the DDM on the job trainings is on five core areas: advanced concepts of planning/formulation of District Action Plan (DAP), implementation of DAP, supportive supervision, communication, advocacy and program management. Faculty, trainers and trainees will be supported by web based distance learning modules and an online repository of documents.

Activity 5: Human Resource Information Systems (HRIS)

PHMI had identified the need for a strong human resources information directory and management

system to allow program leaders and managers to quickly assess key training requirements, gaps and redundancies within program and staff needs. This directory will enable decision makers to create informed, effective strategic plans to ensure a steady supply of trained health professionals and deploy human resources in the correct positions and locations to meet health care needs,
The HRIS strengthening process is designed to foster better understanding of the current health workforce picture in AP. This will prepare decision makers to effectively plan for recruitment, training, retention and replacement of health professionals.
The HRIS system will enable decision-makers to obtain data about domain-wise expertise available in the state.

Activity 6: South to South Collaboration

South-to-South partnerships create an effective platform for building sustainable institutional and human-resource capacity through open exchange of knowledge, information, and professional experience. A regional collaboration will add an important dimension into training program; an international problem-oriented perspective, to enable training of specialists in a multi-disciplinary fashion with a broader target-oriented framework.

PHMI will continue to assist the state and national-level public health workforce to share experiences at the international level – preferably with other USG partners in the South – focusing on areas of HIV prevention, care, strategic information and systems strengthening. PHMI is promoting south to south faculty and student exchange programs between India and other countries and will encourage public health experts to go for study tours, meetings, conferences, and other related short-term trainings.

Activity 7: Instructional Design Trainings

The training on instructional design will be conducted for staff working with NACO, NERO and SACS in priority states. The primary objective is to introduce scientific and pedagogical practices and applications into planning, designing, implementing and evaluating training programs for any cadre of staff, irrespective of the topic, theme or content of the training. The training will be conducted in collaboration with TSU, NIE, GHTM, PHFI and NIHFW. The participants of these training programs will be deputed as master trainers in their field to design and impart training to staff working in their area to strengthen the HIV program at national or state level.

Activity 8: Technical assistance to Districts for District Level Program Management

Based on the success of Field Experts Group (FEG) a concept during development of state and district

level action plans for 2009-2010 with APSACS, PHMI envisages giving continuity to the FEGs with a redefined role of providing TA to the Districts and new district level staff to implement, manage, review, monitor and supervise the programs. Activities for this include:
a) Strengthening of FEGs- to focus on implementation of NACP III at district level who will play an important role in mentorship and supportive supervision of DAPCU staff. The group of experts will be brought in on a voluntary basis to support DAPCU.
b) Mentors training and Periodic workshops- ToT and refresher trainings will be conducted for FEGs to refine their approach towards field mentoring exercise. PHMI will sponsor FEGs for various trainings or workshop or seminar for new ideas and capacity building based on their performance and rapport with district staff.

Activity 9: Web based LMS and Video Conferencing

With increasing need for evidence-based planning and building human resource capacities, sharing knowledge, information and data in an objective, demand driven, and easily accessible manner is a priority in India. The Learning Management System (LMS) is one such web based technology within organization, to collate and provide training courses, knowledge and information online, free of cost to all. Through video conferencing, PHMI plans to provide trainees an opportunity to participate in 2-way communications with resource persons and co-participants. Through this initiative, participants from diverse communities, regions and backgrounds can come together on a single platform ensuring hassle-free learning.

Activity 10: Conference on HIV
As a part of its mandate to provide TA at different levels, PHMI will conduct conferences on HIV- related aspects, which will involve stakeholders, in addition to national and international experts contributing experiences and evidence-based knowledge. The conference would be designed to identify and prioritize various HIV programmatic needs and assist people working in HIV/AIDS programs to develop, manage, and sustain effective and efficient programs guided by validated evidence and findings.
This conference will be unique in providing an opportunity for Public health leaders and decision makers to collaborate face to face. The conference will offer exhibiting opportunities for national, state and district level agencies, public and private corporations and foundations, AIDS service organizations, and pharmaceutical companies.

Activity 11: Technical Workshops for disseminating and sharing information on HIV, Health and Public Health science:

The main objective of technical workshops is to disseminate data, evaluation reports and best practices

on HIV and AIDS related information to understand public health status in AP, TN, NE states and Orissa.

The target group include state health department officers, NRHM and APSACS officials, DAPCU team, public health experts, field level coordinators, district level program officers, health and management institutional heads, training officers of government, non- governmental institutions working in the health sector and the state and district level positive network representatives.

These workshops will be conducted in collaboration with various public health academic, training and research institutions like IIPH, ASCI, HIS and leading universities like Osmania and Pune. PHMI will undertake two dissemination workshops to share the findings of process, output/outcome evaluation reports and best practice learning documents.

Activity 12: Short term thematic in-service trainings for HIV Program managers

As mentioned, NACP-III and NRHM thrust upon strategic decentralization of program plans. PHMI plans to act as a means of enhancing the capacity in terms of management of programs, different components within NACP III, data management, finance management, communication and advocacy and human-resources through STT. The trainings will deliver stand-alone packages on HIV program management development programs with a variety of topics. Some examples include: training on project management, data management, hard skills like Excel, Epi-Info, Power-point, SPSS etc; communication and advocacy; and scientific writing skills and documentation.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10964	**Mechanism Name: APAC**
Funding Agency: U.S. Agency for International Development	Procurement Type: Grant
Prime Partner Name: Voluntary Health Services	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 3,910,000	
Funding Source	**Funding Amount**

GHCS (USAID)	3,910,000

Sub Partner Name(s)

Anbalayam, Tiruchirapalli	Association for Community Empowerment (ACE), Villupuram	Association For Rural Mass India, Villuppuram
Bharatiya Adim Jati Sevak Sangh, Pondicherry	Centre for Human Resource and Rural Development Program	Centre For Social Development, Kanyakumari
Centre For Social Reconstruction, Nagercoil	Chennai Micro Print (P) Ltd., Chennai	Community Action For Social Transformation, Tirunelveli
Community Health Education Society, Chennai	Empower, Tuticorin	Flame Advertising Company, Ltd.
Gramodhaya Social Service Society, Tuticorin	Mass Action for Social Welfare (MASW) - R&T Training	Pache Trust, Tirunelveli
Peace Trust	Perundurai Medical College	RUSS Foundation, Tuticorin
Sahodaran	Snegyitham, Tiruchirapalli	Society For Development, Research & Training, Pondicherry
Society for Education for Village Action and Improvement (SEVAI) - R&T Training	Tata Business Solutions (TBS) - PLHA Helpline	Tuticorin District HIV Postivie People Welfare Society (TDPS+), Tuticorin
Village Beneficiaries Education & Development Society, Karaikkal		

Overview Narrative

Implementation Mechanism Narrative

The AIDS Prevention and Control (APAC) Project, a $47.25 million bilateral program, implements HIV/AIDS prevention, care and treatment programs in Tamil Nadu (TN) and Puducherry in partnership with National AIDS Control Organization (NACO) and local State AIDS Control Societies (SACS). APAC played a critical role in engaging civil society in HIV/AIDS programs and established proven systems and strategies for behavior change, service delivery and targeted evaluations, several of which have been adopted by SACS/NACO. APAC in coordination with other agencies has played a pivotal role in controlling the HIV epidemic in TN, which has noted a steady decline in adult prevalence since 2001 (from 1.13%) to 0.25% in 2008.

In the third phase (April 2007 – March 2012), APAC reduced its emphasis on direct implementation and is moving towards offering targeted technical assistance (TA). The vision and long-term goal of APAC is to gradually shift away from implementation and to play a more strategic role at a regional and national level, based on core competencies and address critical needs of states and the nation. The long-term vision of APAC aligns with the national and PEPFAR priorities of providing TA and engagement of host governments for increased ownership and sustainability.

APAC works primarily in five technical areas: sexual prevention, adult care and support, orphans and vulnerable children, strategic information, and health systems strengthening. It also addresses several cross-cutting areas including gender, economic strengthening, and human resources for health. It maximizes impact through linkages and integration with other programs. In its third phase, APAC will reach over 20,000 Most-At-Risk-Populations (MARPs - which includes female sex workers and men having sex with men), 10,000 migrants and 5,000 people living with HIV/AIDS (PLHA including 1,000 PLHA who are MARPs) in seven districts of TN and Puducherry. Through this effort APAC will demonstrate saturation of coverage, comprehensive combination prevention and provision of holistic care, support and treatment services.

At a strategic level, APAC has been actively engaged in the design of the third phase of the National AIDS Control Program (NACP-III), preparation of various operational guidelines, and is involved in the Mid-Term Review of NACP-III. APAC has provided guidance to NACO on the Behavior Surveillance Survey and the tools developed by APAC have been adopted by NACO and other agencies for the MTR. NACO has assigned APAC to lead the data triangulation and impact assessment of targeted interventions (TI) for MARPs in TN. As national vice-chair for the technical resource group on targeted interventions, APAC provides innovations and key lessons on MARP interventions and is involved in evaluating other donor programs.

APAC also supports the Technical Support Units (TSU) which provide TA to the SACS of TN, Puducherry and Kerala. The TSUs provide TA in five core areas: strategic planning; targeted interventions for MARPs; capacity building; mainstreaming; and public-private partnerships. The TSUs have played a significant role in scaling-up interventions, improving quality, mainstreaming HIV/AIDS programs and leveraging significant resources.

APAC has also been engaged in several system strengthening initiatives that have a long-term and wider impact on health systems. APAC has partnered with the private medical sector to provide counseling and testing, PMTCT, care, support and treatment for PLHA. This is a major accomplishment, as the private medical sector was not very interested in providing HIV/AIDS services in the past.

APAC has also partnered with leading private companies to promote HIV/AIDS programs. A noteworthy contribution has been the establishment of a toll-free help line to PLHA which was initiated in partnership with a TATA group company and has the potential for national scale-up. APAC is also engaging the Indira Gandhi National Open University (the world's largest distance education service provider) for virtual learning programs on a range of health topics. This opens a new dimension in HIV/AIDS training and can substantively reduce the cost incurred in training programs. APAC also leveraged several million dollars worth of resources from the private and public sectors.

Several assessments are being supported by APAC including a Behavior Surveillance Survey for PLHA, impact assessment of home based care programs, assessment of the secondary level public health sector facilities and a study on changing dynamics of sex work. Many of these are the first of its kind in the country and provide critical inputs to strengthen evidence-based programs and assess impact of interventions.

In COP 10, APAC will continue to focus on the five technical areas. APAC will also support structural interventions to address violence against women and factors that increase vulnerability of female sex workers and men having sex with men. APAC will integrate prevention interventions into government systems and demonstrate models of integration to the national program. APAC will undertake assessments of its various activities and evolve a transition plan in consultation with SACS and NACO. APAC will also organize consultations with the government to evolve the nature of engagement in the coming years at the state, regional and national level.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	39,000
Human Resources for Health	390,000

Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection

Budget Code Information

Mechanism ID:	**10964**		
Mechanism Name:	**APAC**		
Prime Partner Name:	**Voluntary Health Services**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	431,400	

Narrative:

SUMMARY

The Tamil Nadu State AIDS Control Society (TANSACS) is the lead player for adult care and support programs in the state. HIV prevalence among pregnant women seeking antenatal care in Tamil Nadu (TN) has seen a steady decline since 2001, from 1.13% to 0.26% in 2007. It is estimated that TN has 150,000 People Living with HIV/AIDS (PLHAs), of which 96% are adults (Males – 70,000, Females 74,000) and the rest 4% are children below 15 years.

The state has an impressive record in terms of the number of outlets providing care and support services, coverage of PLHAs and utilization of care and support services. Currently there are 35 ART Centers (average one per district), 36 adult Community Care Centers (known as CCCs), 5 Pediatric CCCs and 30 PLHA drop-in-centers. The state plans to support an additional 100 link ART centers (link ART centers are located in existing health facilities at district and sub-district level to make the treatment services more accessible to PLHA. Their primary role is enrollment of PLHA in HIV care, basic investigation, and management of pre-ART and to serve as ART drug distribution points located at the sub-district level). 60% of PLHAs have been identified and registered with the ART center, of which 35,000 are utilizing free ART services.

There are still several challenges that need to be addressed. Nearly 20% of the estimated PLHAs are yet to be identified. Even among those identified, only a small proportion is in regular contact with the care and treatment centers. No concentrated efforts are there to identify HIV positive MARPs and provide them with care and support services. Other gaps include: limited emphasis for positive prevention; stigma and discrimination in health care settings; lackluster engagement of the private medical sector; and lack of standardization in provision of care, support and treatment (CST) services. Data on linkages of HIV positive mothers and infants to CST is also limited.

The AIDS Prevention and Control (APAC) Project, plays a complementary role to TANSACS in adult CST programs. APAC has assisted 18 private hospitals for providing care and support services. These hospitals provide clinical treatment to 4,500 PLHA including conducting surgeries and dealing with medical complications and emergencies. These hospitals are mandated to also provide PMTCT, TB, STI services such that all services for PLHA are provided under one roof. The response has so far been mixed. Counseling, follow-up, adherence to a comprehensive PMTCT package and linkages to TB and other social programs offering care services are major challenges faced by the private sector.

Other CST services supported by APAC include: establishment of a helpline for PLHA; supporting positive networks; conducting assessments; and strengthening systems at care, support and treatment centers. APAC has partnered with Tata Business Support Solutions and has launched a toll-free helpline "Hello (+)" for PLHA. The Hello (+) receives nearly 25,000 calls per month and several states have shown interest in adopting Hello + services. APAC also supports the Positive Women's Network to publish a national-level newsletter for HIV positive women. The newsletter covers current programs for PLHA at state/national level, legal aspects, FAQs and documents case studies.

APAC has pioneered the first Behavior Sentinel Survey (BSS) for PLHAs. The PLHA-BSS collects information on: existing knowledge of HIV/AIDS, care and support services; safe sexual practices; utilization of services; quality of life; and stigma and discrimination issues faced by PLHAs. An assessment of home-based care programs has also been initiated. This study will assess the impact of home-based care on quality of life of PLHAs, minimum package of services for home-based care program, costs, and can provide critical insights to policy makers on home-based care.

APAC also provides technical assistance (TA) to TANSACS by supporting a Data Analysis Team (DAT). The DAT is engaged in analysis of data from ART and CCCs; data triangulation; data quality assurance at ART and CCCs; and undertaking rapid assessments on loss to follow-up and reasons for low reach from ICTC to ART centers. The project is also providing TA to the state for branding ART centers including design of patient education materials.

ACTIVITIES AND EXPECTED RESULTS

In FY 11, APAC aims to address the challenges of identifying HIV-positive MARPs in order to increase uptake of clinical and positive prevention services. APAC will also strengthen provision of comprehensive CST services in private facilities and implement task-shifting by building capacity of nurses to function as counselors. APAC will also provide TA to TANSACS for strengthening existing systems and supporting needs assessments.

ACTIVITY 1: Partnering with the private medical sector to provide comprehensive CST services for PLHA. (Budget $ 323,500)

APAC will support one tertiary care hospital, 17 secondary level hospitals and 63 community-preferred private health care providers to provide quality CST services. These facilities will be sensitized about MARP issues, and emphasis will be given to providing CST services to MARPs in coordination with NGOs and CBOs. APAC will ensure 90% of MARPs in intervention districts are referred for CST services. This initiative will help improve early identification of PLHA among MARPs and provide them with CST services.

The physicians, nurses and paramedical staff will be provided regular mentorship on HIV/AIDS management. This will include management of opportunistic infections, counseling, positive prevention, follow-up, HIV-TB co-infection management, PMTCT and the importance of linkages with NGOs and other care continuum providers in the district. Nurses from these facilities will be trained to provide pre and post test counseling and to counsel HIV-positive pregnant mothers on ART adherence, safe sexual practices, nutritional practices, positive prevention and for referrals of STI, TB patients for HIV testing. Systems will be established for ensuring treatment and patient record keeping and for follow-up of HIV-positive patients and their family members for TB and ART adherence. Through this initiative, 5,000 PLHA will be able to get quality palliative care services at these private sector facilities and 500 PLHAs will be treated for TB. 100 ante/post natal women will benefit from this initiative.

Quality assurance of the program will be ensured by the program officers on a monthly basis. Participatory site visits and data quality assurance reviews would be undertaken once in six months. Operations research will be undertaken to identify gaps in the delivery of services. Facility-based surveys, exit interviews, and mystery client surveys would be conducted to understand the project performance.

This initiative will demonstrate an innovative partnership with the private sector, in which ARV prophylaxis and disposable kits for care would be leveraged from SACS; subsidy would be provided by the physicians for clinical care; STI/OI drugs would be provided by private pharmaceutical companies at subsidized rates; and APAC would support the technical training to health care providers. The lessons learned in engaging the private medical sector for providing comprehensive clinical care for PLHAs and MARP PLHAs would be shared with policy makers and the private medical sector associations for replication, scale-up and adoption.

ACTIVITY 2: Building the Capacity of Private Sector Health Care Providers in Palliative Care (Budget $ 107,900)

APAC will support the Institute of Road Transport Perundurai Medical College Hospital (IRTPMCH), a tertiary care medical institution to build the capacity of private physicians to provide HIV/AIDS care. 200 physicians will be trained through this initiative. IRTPMCH will serve as a learning site for other private and public health facilities and will demonstrate: PLHA-friendly clinical care and support services; computerized patient record management and inter-departmental coordination; follow-up of PLHAs; adult and pediatric ART treatment; systems on supply chain management, universal precautions and waste management; and linkages with NGOs, private and government facilities.

APAC will support the institute's library to house a wide-range of journals, books, videos, slides, audios, guidelines, and other materials on HIV/AIDS adult and pediatric care, support and treatment. APAC will also strengthen the centre's capacity for analyzing patient records, conducting operations research, and publishing articles in peer reviewed journals.

ACTIVITY 3: Technical Assistance (TA) to State AIDS Control Societies (SACS) (Budget included under Health System Strengthening technical area)

APAC will provide TA to SACS to strengthen their systems on HIV/AIDS care and treatment. TA will include training SACS team on palliative care policies and guidelines, technical updates through experts, field visits to care sites, monitoring of CCCs, and TA to public institutions involved in HIV/AIDS care and treatment. Operations research will be undertaken to identify the gaps in delivery of services. Facility-based surveys, mystery client surveys will be conducted to assess the effectiveness of support provided by the TSU. APAC will also conduct the second wave of PLHA-BSS and support the DAT.

APAC will also support TANSACS to enter into a memorandum of understanding with 110 private hospitals in Tamil Nadu for scaling-up PMTCT, STI, and HIV-TB management. On-site supportive supervision would be provided for these private facilities on a quarterly basis for ensuring comprehensive PMTCT services. The best practices in implementing PMTCT program in the private sector would be shared with the SACS and NACO. Efforts will be also made to strengthen the HIV-TB coordination at these 110 private facilities partnering with SACS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	86,300	

Narrative:

SUMMARY

Tamil Nadu (TN) has an estimated 7,000 children infected with HIV. They constitute nearly 5% of the total HIV-positive population in the state. In addition, an estimated 10,000 to 12,000 affected children live in TN. While the state has a strong initiative to prevent mother-to-child transmission and provide pediatric ART, emphasis for non-clinical support has been limited. The basic needs of children such as support for education, nutrition, and livelihood remains unfulfilled or sporadically addressed.

Data on orphans and vulnerable children (OVC) are limited. The state does not have clear and reliable information on the number of affected children and on their orphan status (whether single-orphan, double-orphan). Data disaggregated by age and gender is also not available. A comprehensive needs assessment of OVC has not been undertaken. Yet another major challenge is the limited capacity of counselors and health care providers to counsel children. Stigma and discrimination against children at educational and health care institutions continue to be of concern. The number of NGOs with the capacity to intervene with affected children is also limited.

APAC has been advocating with the Tamil Nadu AIDS Control Society (TANSACS) on the need for strengthening OVC programs in TN. This advocacy has resulted in formation of the state-government supported OVC Trust – the first such Trust in any state. The Trust was established in 2009 and the state government through the department of Health and Family Welfare has provided an endowment fund of ($1 million) to initiate the activities of the Trust. APAC provides technical assistance (TA) to the OVC Trust through a team of consultants and supports the OVC secretariat's functions. The consultants are engaged in a size estimation of HIV-affected children and assessing their needs. They contribute to the development of operational guidelines for provision of health and social development programs for OVC and establishing appropriate systems at state and district level for capacity building and monitoring.

ACTIVITIES AND EXPECTED RESULTS

During FY'11, APAC will continue to advocate with the state government and NACO for strengthening OVC programs. APAC will coordinate with different departments including Women and Children, Social Welfare, Youth, Education to mainstream HIV/AIDS programs and leverage existing programs/schemes of these departments to benefit OVC. APAC will provide TA to TANSACS, OVC Trust, NGOs and assist in developing customized programs that meet age, gender and orphan-status specific needs. APAC will also document and disseminate the OVC programs experience to NACO for scale-up to other states.

ACTIVITY 1: Technical Assistance (TA) to the state support OVC Trust. Budget ($ 117,000)

In FY 11, APAC will continue to provide technical support to the state OVC Trust. TA will include: a) supporting consultants for refining the Trust's strategy, operationalize its plans and mobilizing private sector resources; b) undertaking studies to assess needs, gaps and effectiveness of Trust activities; c) developing customized packages that meet age, gender and orphan-status specific needs; d) refining operational plans for mainstreaming with other departments and leveraging existing government schemes/programs from other departments to benefit OVC; and e) developing training curriculums for NGOs, counselors and health educators on OVC and child counseling.

APAC will also strengthen monitoring systems and document case studies of beneficiaries. Efforts will be undertaken in partnership with TANSACS to showcase this program as a model to NACO and other state level agencies. The Trust will also seek to give equal attention to girl children by motivating their parents/guardians to send their daughters to school by providing school fees and other educational materials to help them complete secondary education.

ACTIVITY 2: Support to community based demonstration project for OVC. Budget ($ 117,000)

APAC has phased out of most direct implementation of OVC activities, but will continue to support one sub-partner to implement community based OVC programs. Three hundred children will be reached through this activity and will be provided with a minimum of three OVC services as specified by PEPFAR. These activities will include life skills education training for children; provision of medical, nutritional and educational aid; linkages with counseling and testing services; strengthening households to plan for legal and social support for OVC; and strengthen referral linkages with government, the private sector and other stake holders to leverage resources.

The project will serve as a demo project for the state, by building the capacity of other NGOs to undertake OVC programming. Training modules will be developed and NGO staff will be given a comprehensive training and exposure in designing and implementing a comprehensive OVC program. The participants will be trained on practical and scientific methods to implement and monitor the program. The project will offer handholding and on-site support during the initial implementation of the program.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	345,100	

Narrative:

SUMMARY

Strategic information (SI), which includes monitoring and evaluation (M&E), surveillance and management information systems, is the cornerstone for reliable evidence-based planning and assessing program impact. M&E is now one of the four objectives of the third National AIDS Control Program (NACP-3), reflecting the growing importance of reliable systems for generating, monitoring, and interpreting data.

There is a plethora of data available at the state and national level. Major data sources include: HIV Sentinel Surveillance (HSS), National Family Health Survey (NFHS), Behavior Surveillance Surveys, Integrated Biological and Behavior Surveys, Mapping data of MARP, Truckers and Migrants. In addition there are monthly reports from targeted intervention projects, PMTCT sites, counseling and testing centers, and ART centers which provide information on service outlets and on the number of beneficiaries. The completeness, accuracy and timely availability of this information are critical for program managers and policy makers.

The AIDS Prevention and Control (APAC) project continues to play a strategic and major role in this area. APAC supports the Technical Support Units (TSU) in Tamil Nadu and Kerala. The TSUs with its mandate for strategic planning has ensured increased coordination of data among different agencies, and has improved the capacity of the State AIDS Control Societies (SACS) to develop evidence-based state and district annual action plans. The TSU continues to provide technical assistance (TA) in this area and is building the capacity of SACS officers to analyze reports and provide timely feedback to the reporting units from the field.

APAC has supported a three-member Data Analysis Team (DAT) to strengthen the capacity of the M&E division of Tamil Nadu State AIDS Control Society (TANSACS). The DAT is engaged in building capacity of the ART medical officers and M&E officers Each DAT team member focuses on a particular component and provides data quality assurance support on targeted intervention for MARP; care, support and treatment; and basic services. The DAT team is also involved in collecting data for the modeling exercise.

On a request from NACO, APAC has completed district profiling of all the districts in Tamil Nadu. The district profiles give a summary of the estimated number of Most-At-Risk-Populations (MARPs) and People Living with HIV/AIDS (PLHA) and their locations within the district, trends in the epidemic, and service availability and utilization for each district. APAC is also undertaking a data triangulation exercise in Tamil Nadu which will further provide information on the gaps in services and drivers of the epidemic and will help NACO to reclassify the categorization of districts based on the epidemic profile and vulnerability.

APAC has also conducted the twelfth round of Behavior Sentinel Survey (BSS) for MARPs and has pioneered the PLHA BSS. The PLHA BSS will assess knowledge, attitude, behavior and exposure of PLHA to interventions. APAC is also undertaking an impact assessment of home-based care programs and has conducted an assessment among PLHA on their willingness to pay for care, support and treatment services. A new study to track changing dynamics of sex work has also been initiated.

APAC has in partnership with TANSACS and the State Health Systems initiated a public health facility assessment in 270 public sector hospitals. The assessment will provide information on the infrastructure and systems of different divisions in these hospitals and asses linkages between different divisions and HIV/AIDS programs. The assessment also includes a patient satisfaction survey of clients in counseling and testing centers, and outpatient and inpatient utilization of PMTCT, STI, ART and TB services. This assessment will provide critical inputs relating to the integration of HIV/AIDS services within maternal and child health, reproductive health and other services.

APAC has also assisted TANSACS to form a state-level M&E Working Group that allowed major donors to agree to a common set of indicators for joint tracking, and meet regularly to share information and policy. In addition APAC initiated Geographic Information System mapping the prevention and care services in TN. APAC also builds the capacity of NGOs and CBOs in epidemiology and biostatistics and has established strong systems including periodic data quality audits to monitor and ensure quality of information from the field.

ACTIVITIES AND EXPECTED RESULTS

During FY11, APAC will continue to provide TA on SI to TN. TA will be through placement of consultants at SACS and supporting assessment/studies for evidence-collection and impact assessment. The project will strengthen the capacity of staff of District AIDS Prevention and Control Units in SI specifically on indicators, Data Quality Assurance (DQA), evidence-based planning, analysis of data and providing feedback to field reporting units. APAC will establish working groups that will review study findings and operationalize recommendations through program improvements and policy changes. APAC will also focus on publishing papers in scientific journals and will use its rich experience gained over years to provide TA to other states on strategic information.

Activity 1: TA to SACS and DAPCUs: (Budget; $141,600)
APAC will continue to provide TA to SACS and build the capacity of SACS M&E officers for developing annual action plans, monitoring indicators and establishing systems on data quality assurance. The TSU

and DAT will manage and analyze the data received from agencies implementing prevention and care programs from the state. The TSU and DAT will also carry out periodic validation exercises to authenticate data. The TSU and DAT will build the capacity of SACS and DAPCU M&E officers to analyze and triangulate data, develop scopes of works for new assessments, and for publication of papers in peer-reviewed journals. APAC will also develop a data- base of research organizations, institutions and experts that could be used by SACS for its various research and M&E programs.

Activity 2: Supporting needs assessments and studies: (Budget $159,300)
APAC will continue to take a lead in undertaking studies on prevention, care, support and treatment programs. In FY 11, APAC will conduct the thirteenth round of BSS for MARPs in Tamil Nadu and the second round of BSS for PLHA. APAC will also analyze information coming from its prevention and care programs and support behavioral and biological assessments. All biological assessments will be undertaken only after appropriate ethical clearance from NACO and PEPFAR. For all studies a technical and expert working group comprising of research experts, program managers and policy makers will be constituted to ensure that study findings are converted into policies and actions. APAC will also focus on publishing papers in scientific journals and will use its rich experience gained over years to provide TA to other states on strategic information.

Activity 3: Data Quality Assurance (DQA): (Budget $44,200)

To improve the standards of reporting and recording APAC would standardize reporting formats and explore the option of web-enabled reporting. APAC will also coordinated with TANSACS to link the project data into the existing state GIS. Data quality audits will be undertaken annually to ensure the quality of data being reported by NGO and other partners. In addition regular joint field visits by the program division and M&E division will organized for improved coordination and response. APAC will also support accreditation of NGOs which would ensure greater accountability and quality of reporting. APAC will train 64 staff from eight NGOs in three districts in the areas of data collection.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	1,856,500	

Narrative:

SUMMARY

The third phase of the National AIDS Control Program (NACP-3) has underscored the need for system strengthening and developing appropriate policies/guidelines to facilitate the scale-up of high quality HIV/AIDS activities. The AIDS Prevention and Control (APAC) Project has in the last few years been

actively engaged in health systems strengthening at state, district and community levels. Primary focus has been on leadership and governance, improving effectiveness of service delivery and strengthening information systems for improved monitoring and evaluation.

At the state level APAC focuses on strengthening the health systems of the Tamil Nadu State AIDS Control Society (TANSACS), primarily through assistance to the Technical Support Units (TSU) and technical consultants placed at TANSACS. The TSU has strengthened the capacity of SACS officials in both fiduciary and program planning and management. SACS officials are trained on the national operational guidelines and assisted to develop micro-plans for each officer and department. This has increased the efficiency of SACS officers and in timely roll-out of programs.

The TSU team has also built the capacity of State AIDS Control Societies (SACS) to develop and implement a mainstreaming strategy in the states of Tamil Nadu and Kerala, which has resulted in six ministries integrating HIV/AIDS into their annual action plans and the leveraging of nearly two million USD. These ministries have supported establishment of counseling and testing in hospitals and prisons; provided nutritional support for HIV-infected women and orphans and vulnerable children (OVC); provided safe spaces for People Living with HIV/AIDS (PLHA); and supported income generation programs including procurement of products produced by PLHA and Most-At-Risk-Populations (MARPs). Additionally, the TSU have also built the capacity of SACS officials to engage and partner with the private medical sector for PMTCT, CT and care and support services.

APAC provides technical assistance and is engaged in building the capacity of TANSACS to establish and manage the state-supported Trust for OVC. The OVC Trust which is chaired by TANSACS has representations from 13 ministries, and the state government has provided an endowment of $1 million to provide health and social welfare programs to OVC. APAC is also building the capacity of state-level lawyers collective in coordination with TANSACS to provide legal aid support for PLHA and MARPs.

At the district level, APAC is involved in building the capacity of the District AIDS Prevention and Control Units (DAPCU) in program and fiduciary management and for inter-departmental coordination to ensure the government health and social welfare programs benefit MARPs and PLHA. At the community level, APAC builds the capacity of community members in leadership, communication, project management and assists them to form community-based organizations. District and state-level peer education associations of MARPs have been formed and capacitated to plan for community development. APAC is also involved in improving the governance of state and district- level PLHA networks.

APAC is building the capacity of the private sector to take a lead role in HIV/AIDS prevention and care services. In a recent development, APAC has partnered with Tata Business Support Solutions (a

company that is part of the TATA business conglomerate) and built their capacity to support a toll-free helpline (Hello +) for PLHA. The technical knowledge and expertise gained through this initiative has encouraged TBSS to plan for a pan-India program.

APAC has also identified and built the capacity of a network of private medical sector clinics for provision of HIV/AIDS care, support and treatment. This initiative is a bold approach to engage the private medical sector which has thus far been reluctant to provide HIV services. This initiative has also strengthened their patient record maintenance capacity, inter-departmental coordination, supply chain management systems and linkages with other NGOs and civil society.

APAC is partnering with the Indira Gandhi National Open University (the world largest distance education service provider) and is building their capacity to support virtual learning programs on a range of health topics. This opens a new dimension in HIV/AIDS training and can substantively reduce the cost incurred in training programs.

APAC has in partnership with TANSACS and the State Health Systems initiated a public health facility assessment in 270 public sector hospitals. The assessment provides information on the infrastructure and systems of different divisions in these hospitals and asses linkages between different divisions and HIV/AIDS programs. The assessment will also grade each hospital's performance and the overall district's performance (cumulative performance of all hospitals combined) and establish systems to improve their performance over a period of time. This would facilitate overall health systems development at the state-level.

APAC is also building the capacity of TANSACS to deliver high quality counseling and testing services. APAC will be supporting a counseling hotline facility at TANSACS to provide 24x7 guidance to counselors and strengthening the capacity of district counseling and testing supervisors through on-site support and exchange visits. The counseling and testing (CT) centers will be graded and APAC will support the individual CT center to develop plans to improvement and achieving performance and quality benchmarks.

ACTIVITIES AND EXPECTED RESULTS

During FY11, APAC will continue to provide technical assistance on Health Systems Strengthening to Tamil Nadu, Puducherry and Kerala. Technical assistance will be through placement of consultants at SACS, representations in district, state, regional and national level working groups, and supporting new

and innovative initiatives that encourage leadership and system strengthening. APAC will support technology initiatives for quicker and improved decision making, health financing, strategy reviews, gender, integration, mainstreaming, building local leadership and task shifting initiatives.

ACTIVITY 1: Health System Strengthening of SACS, DAPCU and other government health departments: (Budget: $911,000)

APAC will continue to support the TSU, Data Analysis Team (DAT), DAPCU and orphans and vulnerable children (OVC) consultants to ensure system strengthening at state and district level. Individual staff assessments at SACS and DAPCU level will be conducted and mentorship plans will be devolved with consultants. APAC will identify established institutions that are capable of building the capacity of SACS and DAPCU officials on a range of project management and technical topics and engage them to provide support, such that technical assistance (TA) can be institutionalized and a phased exit plan for TSU, DAT and OVC consultants can be evolved. APAC will provide TA to SACS on new and emerging areas such as public-private partnerships, integration of HIV/AIDS programs with other health services, and health financing. APAC will also support a three-member consultant team to be located in the State Rural Health Mission Office, State TB Office and Urban Heath Office to facilitate greater coordination between TANSACS and other health offices and improved integration with HIV/AIDS programs.

ACTIVITY 2: System strengthening of positive networks: (Budget $ 221,000)

APAC will undertake an impact assessment of the system strengthening of PLHIV networks supported by APAC and other agencies. The experiences will be shared with SACS and other agencies and a coordinating committee will be established to identity the type of TA and capacity building programs that can best support PLHA networks. The committee will also analyze areas of resource overlap and evolve appropriate mechanisms to ensure greater coordination between agencies. APAC will provide TA to the Positive Women Network to document their experiences, case studies and challenges and disseminate these to policy makers at the national and state level. APAC will also support a professional management firm to formulate business development and sustainability plans for PLHA networks.

ACTIVITY 3: System strengthening in private sector: (Budget $366,800)

APAC will continue to provide TA to the private sector and build their capacity for an enhanced response in HIV/AIDS programming. APAC will partner with well-established private sector organizations to

promote public-private partnerships in HIV/AIDS programs and will continue to support TBSS for Hello+ helpline. APAC in coordination with TANSACS will also support accreditation of the private medical sector hospitals engaged in HIV /AIDS care, support and treatment services. APAC will also support pilot initiatives on health financing and explore task shifting options in private hospitals.

ACTIVITY 4: Building Local Leadership (Budget $ 200,000)

APAC along with TANSACS will support capacity building initiatives with the legislative members and women lawyers to advocate HIV/AIDS issues, address stigma, discrimination and protection of legal and human rights of PLHA and MARPs with a greater emphasis on women. APAC will also establish systems in coordination with SACS and donors to support outstanding and emerging leaders for their contributions to health system strengthening initiatives and HIV/AIDS programs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	1,121,700	

Narrative:

SUMMARY

Tamil Nadu (TN) has an estimated 115,000 most-at-risk-populations (MARPs), which include Female Sex Workers (FSW) – 65,000, Men having Sex with Men (MSM) – 45,000, and Injecting Drug Users (IDU) - 5,000. Three agencies the TN State AIDS Control Society (TANSACS), AIDS Prevention and Control (APAC) Project, and the Tamil Nadu AIDS Initiative (TAI), support MARP interventions in TN. There is clear geographical demarcation between the agencies to avoid overlaps. Truckers and migrants are the other two priority groups for sexual prevention. HIV prevalence among FSW (3.6%), MSM (6.6%), and IDU (16.8%) continues to be a cause of concern.

Prevention strategies include: a) saturating coverage of MARPs in urban and high-concentration areas through targeted interventions, b) the Link Workers program (Link Workers are volunteers identified from villages to reach MARPs, vulnerable populations and people living with HIV/AIDS (PLHIV) in rural areas to promote prevention messages and for linkages with care, support and treatment services), c) interventions for short-stay single male migrants and long-distance truck drivers through NGOs and mainstreaming with relevant ministries, d) programs for women and youth, and e) increasing access to condoms, STI treatment and counseling and testing services.

APAC has played a very important role in sexual prevention programs These include: mapping of MARPs in TN; saturating coverage of MARPs in seven districts and Puducherry; establishing Technical Support

Units (TSU) to provide technical assistance (TA) to State AIDS Control Societies in TN, Puducherry and Kerala; supporting community-preferred clinics (Nakshatra +) for STI services to MARPs; implementing Link Workers program in all high-prevalence districts in TN with resource support from NACO; and conducting studies for evidence and impact assessment.

TN has demonstrated significant progress in covering MARPs population and increasing access to condoms and STI services. HIV prevalence among MARPs in TN is lower than the prevalence among these groups nationally. However, several challenges still persist in sexual prevention. Key challenges include: inconsistent condom use; limited focus on MSM and IDU; lack of a standardized package of prevention services; inadequate systems for early identification and outreach to new MARPs; limited access to and use of counseling, testing, care and support services; minimal engagement of the community in planning, implementation and monitoring of projects; and low emphasis on comprehensive, structural interventions including programs for addressing violence, trafficking, prevention of second-generation sex workers, and linkages to health and development services

ACTIVITIES AND EXPECTED RESULTS

During FY'11, APAC will focus on supporting interventions in three districts to demonstrate saturation and comprehensive combination prevention interventions. APAC will also increase its emphasis on providing TA to State AIDS Control Societies (SACS) and District AIDS Prevention and Control Units (DAPCU) through human resource capacity building, strengthening existing project management systems and supporting need-based assessments. The project will also work with SACS and National AIDS Control Organization (NACO) to transition some of its interventions to the state.

ACTIVITY 1: Demonstrating saturation coverage and comprehensive prevention in selected high-prevalence districts.

APAC will support NGOs and CBOs in three districts for interventions with MARPs. The program will ensure 90% coverage of MARP in these districts. APAC will collaborate with NGOs and condom social marketing organizations to ensure access to male and female condoms in all intervention sites. Regular STI screening for MARPs will be ensured through accompanied referrals to Nakshatra + centers and public sector clinics. Periodic NGO and Health Care Provider meetings will also be organized by APAC for improved coordination and sharing of information. APAC will strengthen the capacity of peer educators to provide quality behavior change communication, mobilize community, and train them on leadership, communication and project management. The peer educators and NGO outreach workers will also be trained on identifying and providing support for MARPs who are HIV infected.

APAC will increase access to counseling and testing (CT) services to MARPs through a combination of accompanied referrals to government CT centers and supporting mobile CT teams to visit NGO sites on a fixed schedule. The importance and advantage of early testing will be highlighted by NGOs and Peer Educators during their personal and group interactions. Through these efforts the project aims to ensure 80% of MARP undergo HIV testing annually. The project will register MARP PLHAs and regularly follow-up to ensure care, support and treatment services. APAC will also facilitate in establishing a corpus fund to support MARP PLHAs on alternate occupations, thereby reducing the spread of HIV/AIDS further. APAC will develop a module for positive prevention specific to MARPs and build the capacity of NGOs to provide positive prevention and follow-up counseling. APAC will adapt the CDC tools on positive prevention. The use of peer educators as lay counselors for positive prevention will also be explored.

Community meetings involving MARPs will be undertaken on a monthly basis to share progress, highlight gaps, track sites reporting violence, and identify new entrants to be reached. NGOs and CBOs will be regularly trained on the importance of comprehensive combination prevention and interventions modified to include behavioral, biological and structural programs. A common minimum package on prevention services will be developed and introduced. Other social and health issues faced by MARPs including access to family planning services, adult literacy, alternate income generation etc will be addressed through trainings, advocacy and linkages with the concerned government departments.

A clear strategy for greater involvement and ownership of the community will be developed for each district in coordination with NGOs, and progress will be regularly monitored. APAC will monitor the progress of activities through regular field visits by staff and consultants, and through experience sharing and review meetings. Annual data quality audits of NGOs will also be undertaken.

In-line with national and PEPFAR priorities, APAC has been gradually shifting its focus from implementation to TA and strategic support. A transition plan will be developed by APAC to shift additional direct implementation activities (including transitioning sub-partners involved in MARP and migrant interventions) to SACS funding. A transition committee involving APAC, TANSACS, NACO and other stake holders will be formed to ensure smooth and phased transitioning. The possibilities for transitioning need to be explored in consultation with NACO.

ACTIVITY 2: Technical assistance to SACS to strengthen interventions with MARPs. Budget amount:

APAC will increase its emphasis on TA to SACS. APAC will continue to provide assistance to the TSUs in TN, Puducherry and Kerala. The TSUs will support SACS to develop evidence-based, district and state annual action plans, and will establish systems for enhancing quality, coverage and community

ownership. The TSUs will also take a lead role in providing technical assistance on IDU and MSM programs in these three states. APAC in consultation with NACO and SACS will establish benchmarks for capacitating SACS team and for a gradual transitioning of TSU support

APAC will support a team of technical and financial consultants to strengthen the capacity of DAPCUs to plan, implement and monitor the district action plans, through onsite mentorship support and development of guidelines. The consultants will also build the capacity of DAPCU staff to mainstream HIV/AIDS within relevant government ministries/departments and to ensure that health and social schemes benefit MARPs and migrants.

APAC will support a consultant at SACS for data quality assurance in MARPs programs and for coordination between different agencies for ensuring the "Three Ones" principle. The consultants will also identity potential areas for assessment areas among MARPs and migrants. APAC will also build the capacity of the State Training and Resource Centre (STRC) in the areas of comprehensive prevention, community mobilization, project management, social marketing, and application of the national operational guidelines for MARPs and migrant interventions. APAC will support SACS and STRC to establish a repository of tools, training modules, communication materials and research studies on MARPs and migrants at the state level. APAC will also support the state in developing communication strategies and prototypes for communication materials specific to different populations.

APAC will support a team to provide management oversight to the agencies involved in Link Workers Program. APAC will extensively document the MARPs, migrant and Link Worker intervention experience and disseminate experiences and tools to NACO, SACS and other stakeholders. The three districts supported by APAC will be developed as learning sites for other states to learn on saturating coverage, reaching MARP PLHAs, integration with other health services, advocacy, community ownership, and mainstreaming. APAC will also support a state-level migrant association to demonstrate migrant interventions. This will be different from the existing NGO-managed interventions.

APAC will conduct Behavioral Surveillance Surveys and other assessments, to assess gaps and impact of MARPs and migrant programs. APAC will use the study findings to improve the quality of programs and advocating with program planners for policy change.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	69,000	

Narrative:

SUMMARY

Injecting Drug Use (IDU) in India has been predominantly identified with the Northeast region of the country. However, recent estimates point to new pockets of IDUs emerging in Kerala, West Bengal, Orissa, Punjab, Chandigarh, Tamil Nadu (TN), Maharashtra and Delhi (Source: NACO SS, 2007). The estimated IDU population in India is approximately 164,820 (Source: Lancet, Mathers et al, 2008) of which nearly 3,000 IDU are estimated to be in TN and 2760 in Kerala (Source: APAC 2008 mapping). HIV prevalence among IDU nationally is 7.2% with TN and Kerala reporting 17% and 8% respectively.

As per national Behavioral Surveillance Survey (2006), 62% of IDU in TN and 11% of IDU in Kerala continue to use used needles/syringes. In TN, nearly 50% of IDU had not sought treatment for STI despite having symptoms and only 21% had consistently used condom with a commercial/non-regular partner. The scenario is still worse in Kerala with only 12% of IDU reporting consistent condom use with their partners. HIV testing is also a cause of concern with only 22% of IDU in TN and 42% in Kerala reporting ever undergoing a HIV test.

NACO has been vigorously pursuing a harm reduction approach to stem the spread of HIV from IDUs to the general population. A major development in the recent past is the approval by the Government of India (GOI) of oral substitution therapy for IDUs. In TN two NGOs have been implementing buprenorphine substitution programs for more than five years, particularly catering to IDUs in Chennai. An additional three such centers have been planned by the Tamil Nadu State AIDS Control Society (TANSACS). Currently one center in Chennai has been accredited by NACO for providing buprenorphine.

Nine NGOs and one CBO are currently implementing prevention programs among IDU in TN. All nine NGOs and the CBO are supported by TANSACS and they reach nearly 60% of the estimated 3,000 IDU population. TANSACS is planning to support additional NGOs to ensure saturation of coverage. The TN government has supported statewide sensitization of police officials at all levels, which has vastly helped in implementation of prevention programs among IDUs in the state. The purpose of this sensitization is to bring about acceptance of harm reduction as a strategy for effectively combating HIV among IDUs and thereby reducing harassment of IDUs and health workers. 5,372 police men and women in TN were sensitized through this initiative. APAC had supported TANSACS in developing the module and training the trainers.

APAC supports sexual prevention interventions in seven districts of TN and Puducherry. Since the number of IDU in APAC intervention districts is small, APAC is using a "composite intervention strategy" i.e., it has trained its sub partners engaged in other sexual prevention to reach IDU in the intervention areas. A total of 230 IDUs were reached through APAC sub-partners. APAC does not support provision

of needles or drugs but is involved in behavior change communication, condom promotion, advocacy, referrals for abscess management, counseling and testing, treatment of sexually transmitted infections, and detoxification. APAC also supported the mapping of IDU in TN, Puducherry and Kerala and provides technical assistance to Kerala State AIDS Control Society for implementing IDU programs.

ACTIVITIES AND EXPECTED RESULTS

In FY 11, APAC aims to demonstrate models of IDU coverage using a composite intervention strategy. APAC will also provide TA to TANSACS and Kerala State AIDS Control Society for strengthening existing systems and supporting needs assessments for IDU programs.

ACTIVITY 1: Demonstrating IDU programs through composite interventions.
Budget amount: $ 78,000

In three districts (Kanyakumari, Kancheepuram and Trichy) APAC will support composite interventions to reach IDU. Through this initiative, APAC will be able to reach 100% of the estimated 220 IDUs in the three districts and demonstrate the effectiveness of composite interventions in sites that have a smaller number of IDU. APAC feels that this is a cost-effective strategy to reach IDU where IDU numbers are not large.

APAC will support comprehensive programs for IDU following NACO guidelines. Services will include: a) information on HIV/AIDS/STI, b) needle/syringe exchange program (NSEP), c) condom distribution, d) abscess management, e) counseling on safe injection practices and safer sex practices, f) advocacy, g) referrals for substitution therapy, h) care and treatment for IDUs who are HIV positive, and I) referrals for de-addition through linkages established with centers supported by Ministry of Social Justice and Empowerment (MSJE). The outreach services will also focus on spouses and sexual partners of IDU, providing referrals for testing, sensitizing on issues related to IDU and other clinical services. Although NSEP, substitution therapy, condoms and drugs are not supported through USG funds, mechanisms for leveraging these resources have been set- up in line with the national mandate by NACO.

NGO partners will include ex-users as part of the outreach team. This will greatly help, since these ex-users know how to address challenges faced in the area of service utilization and will be have greater acceptance by IDUs. Female members who are part of the outreach team will deliver services among partners/spouses of IDU. This will facilitate uptake of services from spouses/partners of IDU.

Special emphasis will be placed on reaching out to IDU who are HIV-positive and their family members. Services to positive IDU and family members will include distribution of condoms; counseling of safe injecting practices, safer sexual practices and on home care and follow-up for adherence; HIV testing of spouses/regular sex partners; referral to opioid substitution programs and de-addiction services; and linkages to care, support and treatment centers.

APAC will provide training to NGO staff implementing programs among IDU on specific components addressing prevention and care and treatment strategies. Nearly, 25 NGO staff, 5 community health educators and 30 peer educators will be capacitated to provide comprehensive prevention and care services to IDU and their sex partners. Monitoring of services will be done through experience sharing meetings and visits by technical officers and consultants who have experience in implementing programs among IDU.

The composite intervention experiences in IDU intervention will be documented by APAC and shared with SACS, NACO and other organizations engaged in IDU programs.

ACTIVITY 2: Technical assistance to State AIDS Control Societies (SACS) for effective implementation of IDU interventions. Budget: (* included under OHSS)

APAC through the Technical Support Units (TSU) will provide assistance to SACS in TN, Puducherry and Kerala to ensure saturation of coverage of IDUs at the state level. The TSU will also coordinate with SACS to enhance the quality of programs and to accelerate roll-out of medication-assisted treatment for IDU. The TSU will develop a comprehensive prevention-to-care continuum package of services for IDU interventions and will build the capacity of the State Training and Resource Centre to train NGOs engaged in IDU programs. APAC will also identify a panel of national/international consultants and identify learning sites that can be used by the State AIDS Control Officials and NGO staff from these three states. A dedicated website will be established and will function as a repository for communication materials, training modules and research studies on IDU. The possibility of providing telephone counseling to IDU through Hello + (Hello + is a toll free helpline which has been established by APAC in partnership with TATA Business Support Solutions for providing counseling and health education to people living with HIV/AIDS) will also be explored. APAC will also support needs assessments for evidence collection and impact assessment.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10975	**Mechanism Name: Avert Society**
Funding Agency: U.S. Agency for International Development	Procurement Type: Grant
Prime Partner Name: Avert Society	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 2,200,000	
Funding Source	**Funding Amount**
GHCS (USAID)	2,200,000

Sub Partner Name(s)

Action Research Centre, Thane	Alert India, Navi Mumbai - Migrant	Alert India, Thane-Mobile ICTC van
Arphen, Navi Mumbai - migrant	Astitva Hijra Thane	Bharatiya Adim Jati Sevak Sangh (BAJSS) Nagpur-Mobile ICTC van
Bharatiya Adim Jati Sevak Sangh, Nagpur	Committed Communities Development Trust	Community AIDS & Sponsorship Programme, Mumbai
Comprehensive Rural Tribal Development Program- Nagpur, Migrant	Council for Rural Technology and Research Institute Aurangabad (Migrant)	Dr. Babasaheb Ambedkar Vaidyakiya Prathisthan- Migrant-Aur'bad
Dr. Babasaheb Ambedkar Vaidyakiya Prathisthan, Aurangabad-Mobile ICTC van	Employers' Federation of India (EFI)	Family Planning Association of India (FPAI), Thane
Family Planning Association of India, Thane-Mobile ICTC van	Francois Xavier Bagnoud International	Gram Vikas Mandal, Aurangabad
Gram Vikas Mandal, Jalna	Gramin Vikas Mandal, Jalna-Mobile ICTC van	Indian Institute of Youth Welfare
IRCS - Nagpur - FSW	Janakalyan Samiti, Solapur	Jeevansamrudhi Project - DIC - Jalna
Kamalini Nilmani Charitable Trust-AAS Centre for Human Hope-	Krishna Charitable Trust	Late R.Y.Gaikwad Memorial Trust, Solapur (Migrant)

Migrant-Thane		
M/s. Lad & Nagaral Associates	Mahila Vikas and Shishu Sanskar Kendra, Thane- Migrant	Manav Vikas Bahuuddeshiya Sanstha
Marathwada Gramin Vikas Sanstha, Vaijapur	Mook Nayak Swayamsevi Sanstha, Sangli	Network of Kolhapur, Kolhapur - DIC
Network of Solapur Positive People (DIC)	Nirmala Niketan College of Social Work	NSP (Disha), Satara - DIC
P.K. Chopra and Company Chartered Accountants	Prerana Samajik Sanstha	Project Vaibhavi (NNP+) (DIC)
Rashtiya Swastha Prabodini, Thane (Migrant)	Sankalp , Kalyan - IDU	Sarathi Trust
Setu Charitable Trust	Sevadham	Shapath
Society for Human Education and Development(SHED)Thane (Migrant)	Solapur Zilla Samajik Karya Samiti	SOS Foundation (WPI Nashik)
Swami Vivekananda Medical Mission (SVMM), Nagpur (Migrant)	Swayam Shikshan Prayog (SSP), Solapur (Migrant)	Tata Institute of Social Sciences
TBD	The Humsafar Trust, Thane	UDAAN
UDAAN, MSM	Vanchit Vikas	Vasai Region AIDS Control Society (VRACS)-Migrant-Thane
Verala Development Society (VDS) Solapur-Mobile ICTC van	Verala Development Society (VDS), Solapur (Migrant)	Wokhardt HIV AIDS Education and Research Foundation
Young Mens Christian Association, India		

Overview Narrative

The Avert project is a bilateral program implementing HIV prevention, care and treatment activities in five high-prevalence districts of Maharashtra State. The population of these five districts is 20 million and the HIV prevalence ranges from 0.5 % to 1.75 %. Overall, prevalence among pregnant women attending antenatal clinics (ANC) in the state is above the average for India at 0.67%, though this is a decline from 1.5% in 2003. There are a number of factors that contribute to Maharashtra's vulnerability to the HIV epidemic. It is bordered by other states that have well-established and growing HIV epidemics (Karnataka and Andhra Pradesh). There is extensive migration to and from these states, and there are major transportation routes connecting Maharashtra to them. Maharashtra is a major destination hub for

migrants from various states of India. Additionally, Mumbai and several other districts have well recognized places where sex workers operate. The total estimated number of HIV positive persons is over 460,000 which accounts for 20% of the total estimated HIV infected persons in the country and second highest after Andhra Pradesh with 485,000 HIV positive persons.

The Avert project supports the National AIDS Control Program (NACP III) and works in collaboration with Maharashtra State AIDS Control Society (MSACS). MSACS is implementing a comprehensive HIV prevention, care and treatment program throughout the entire state of Maharashtra that is supported by the Mumbai District AIDS Control Society (MDACS). The Avert project and the Bill and Melinda Gates Foundation (BMGF) are the two other major programs that complement the efforts of MSACS in scaling up HIV prevention, care and treatment programs. BMGF's primary focus is supporting prevention programs among most-at-risk-populations (MARPs) in 13 high prevalence districts in Maharashtra. UNICEF provides technical assistance (TA) on prevention of mother to child transmission (PMTCT). The Clinton Foundation is supporting pediatric antiretroviral therapy (ART) services. The state also receives funds from the Global Fund for AIDS, Tuberculosis, and Malaria (GFATM) for scaling-up integrated counseling and testing (ICTC) and care and treatment programs. In addition, USG supports Johns Hopkins University (JHU) and the Hindustan Latex Family Planning Promotion Trust (HLFPPT) to assist MSACS in designing behavior change communication (BCC) and condom social marketing programs for most at risk populations (MARPs).

The overarching goal of Avert project is to complement the efforts of Maharashtra State in reducing the prevalence of HIV from 1% to less than 0.5%; and in improving access to care and treatment services in five high-prevalence districts. In addition, Avert project through the technical support unit (TSU) is playing a critical role in building the capacity of the MSACS which is spearheading the HIV prevention efforts to halt and reverse the epidemic in the state.

The Avert project focuses on saturating coverage of MARPs such as female sex workers (FSWs), men who have sex with men (MSM), and migrants, implementing community mobilization activities to increase the uptake of counseling and testing, PMTCT, and care and treatment services in the five high-prevalence districts. Additionally, the Avert project is mandated to implement workplace interventions in the entire state.

In June 2011, the Avert project will enter the third phase of programming. It is expected that Avert project will then begin transitioning its direct implementation activities to MSACS and focus on providing TA to build the capacity of the MSACS and local organizations.

Key Ongoing Activities:

• Support and strengthen the capacity of over 70 nongovernmental organizations (NGOs) and community-based organizations (CBOs) to saturate the coverage of MARPs to promote behavior change such as

consistent condom use, and seeking STI treatment and counseling and testing (CT).
• Implement link worker (LW) programs to mobilize the MARPs in rural areas to utilize prevention, CT, PMTCT, care and support and ART services.
• Support eight drop-in centers to implement home-based care and provide HIV/AIDS services to 2,250 orphans and vulnerable children infected and affected by HIV/AIDS.
• Scale-up and strengthen workplace intervention programs with organized and unorganized industrial sectors vulnerable to HIV/AIDS in five districts in Maharashtra.
• Create models of HIV prevention programs among short-stay migrants and support replication of the model in the state and national level.
• Conduct activities to ensure a strong evidence-base for planning and implementing HIV programs, including mapping studies and studies of access to and quality of services, and needs assessments to support demand generation. An Integrated Biological and Behavioral Assessment (IBBA) in the Avert districts have been approved by the Research Group at NACO and will be submitted for ethical clearance.
• Support the TSU, to build the capacity of MSACS, MDACS and Goa State AIDS Control Society (GoaSACS) in grants management, monitoring, institutional capacity building, mainstreaming and public-private-partnership programs. This TA is expected to be phased out by 2012.
• The Avert project is collaborating with Christian Medical College (CMC), Vellore to strengthen the strategic information system (SIS) at the state level. TA has been provided to carry out co-relational analyses of ANC surveillance, CT and ART services.
• Avert project is also seeking TA from CMC, Vellore in strengthening the human capacity building initiatives in Maharashtra State. As part of this effort, it plans to build the capacity of institutions and individuals, adopting a systems approach to curriculum development and training in order to improve the quality and sustainability of training. Most importantly, this will be a model for replication in other states and for guiding national policies on human capacity building.
• Program Achievements and Innovations:

• The Avert project has established robust project management systems such as NGO selection, monitoring, capacity building and evidence-based programming. This has resulted in establishment of a network of over 70 NGOs implementing prevention programs, care and support programs for MARPs in the five Avert priority districts including improving the quality of interventions.
• Developed models of workplace interventions for public and private sector industries, business associations and the unorganized sector and developed methodologies to segment targeting in workplace interventions to ensure that the most-at-risk industrial sectors are reached. Based on these models, workplace interventions are being scaled-up and targeted to those industries and informal workers most vulnerable to HIV/AIDS.
• Over 3,000 peer educators trained to carry out behavior change activities among MARPs.
• The Avert TSU has played a significant role in assisting the SACS to scale-up and strengthen 84

targeted intervention programs in Maharashtra and 19 in Goa; and 60 public-private-partnerships on integrated counseling and testing centers (ICTC) and 1,260 STI franchising clinics in Maharashtra. The TSU has assisted MSACS in mainstreaming HIV/AIDS into the National Rural Health Mission (NRHM), women and child development and Panchayat Raj departments.

• Consistent condom usage among sex workers has increased significantly from 70% in 2004 to 90% in 2008.

The Avert project will develop strategies to mitigate gender concerns in HIV/AIDS programs for MARPs and other vulnerable populations. Specifically, it will train NGOs to address the double stigma and discrimination MARPs face in community and health care settings. The prevention program for FSWs includes a strategy to access legal services to address violence and coercion by police and clients. Programs such as training of women PLHIV on vocation skills and linkages to banks are designed to improve access to income and productive resources.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	360,875

Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Mobile Population
Workplace Programs

Budget Code Information

Mechanism ID:	**10975**		
Mechanism Name:	**Avert Society**		
Prime Partner Name:	**Avert Society**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**

Care	HBHC	156,740	

Narrative:

Summary:
The Avert project is demonstrating an integrated care program for adults and orphans and vulnerable children (OVC) through a family centric approach in four Avert priorities and five of the districts where the Maharashtra State AIDS Control Society (MSACS) is implementing HIV/AIDS activities. Family is the key for the health of people living with HIV/AIDS (PLHIV) - but families need skills in caring for the sick and dealing with pain and counseling skills. The Technical Support Unit (TSU) will support Avert project in transitioning the NGOs to MSACS including building their capacity to manage the activities.

ACTIVITIES AND EXPECTED RESULTS:

ACTIVITY 1: Integrated Adult care and OVC Programs:

The Avert project has learned from experience that separate adult care and OVC programs are not feasible and cost-effective in the context of India's concentrated epidemic. Hence, the project has initiated a demonstration program on integrated family-centered adult care and OVC in FY08. Currently, the Avert project is supporting nine PLHIV networks to implement integrated adult care and OVC programs. The OVC component is added to adult care program with addition of two staff (Life Skills Education Teacher and a Nurse). In addition, the adult care providers are also trained on OVC activities such as counseling, medical care, referral support and documentation. The integration has saved the cost of supporting a separate NGO for staffing, rent and other infrastructure support. These programs are reaching 13,775 adult PLHIV and 1,500 OVC. In FY09, the Avert project will reach an additional 5,400 adult PLHIV and 3,000 OVC. The activities for adult PLHIV include psychosocial support including counseling, medical care, referral to ART services, legal aid and linkages to socioeconomic programs The OVC package of services includes psychosocial support, medical care, nutritional support based on assessment, life skills education, formal and non-formal schooling and accompanied referrals to pediatric testing and ART services. In FY09, the Avert project will decentralize the program by forming sub-district level PLHIV networks and building their capacity to provide care services closer to the community. The sub-district level PLHIV networks will form a crisis committee to address stigma, violence, harassment, and other forms of physical and emotional abuse. A district-level forum will be constituted with representatives from the sub-district level networks to undertake advocacy at places of work and in health care settings. The PLHIVs will be trained as speakers to encourage disclosure, normalize HIV/AIDS and create a non-threatening environment for PLHIV. The Avert project will also develop referral systems (between most-at-risk-population (MARP) nongovernmental organizations (NGOs) and Care program and strategies to provide user-friendly services to MARPs. In addition, the Avert project is

forming a network of HIV-positive MARPs who will play a critical role in improving access to care and treatment services for MARPs.

In FY10, the Avert project will conduct an evaluation and transition the nine integrated adult care and OVC programs to MSACS. The TSU will assist MSACS in establishing systems to absorb the nine care programs. The best practices of the demonstration program will be documented and disseminated at national and international levels.

ACTIVITY 2: PLHIV Insurance Program

In collaboration with the Population Services International (PSI) Connect project, a PLHIV insurance program will be initiated through the nine integrated care programs. With technical assistance (TA) from PSI-Connect Project, a feasibility study will be conducted to design the insurance scheme for the PLHIVs in Maharashtra State. The findings will be shared with the insurance companies and a partnership will be formed with the company who comes forward to take up the initiative.

ACTIVITY 3: Program on Prevention with Positives

The national program has accorded low priority to prevention for HIV-positive people. The Center for Disease Control (CDC) program in India has developed the Prevention-with-Positives Follow-up Counseling Tool Kit. The toolkit has a standardized curriculum that covers advanced issues of living with HIV/AIDS, including stigma and discrimination, disclosure, mental health, safer sex, care and prevention. In FY10, Avert project will provide technical support to MSACS on positive prevention and follow-up counseling. Avert project will support the MSACS to train counselors of integrated counseling and testing (ICTC) and ART centers in positive prevention strategies including skills to use the Prevention-with-Positives Follow-up Counseling Tool Kit.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	213,985	

Narrative:

SUMMARY

One of the important objectives of the care and support strategy of the Avert project is to ensure the well-being and protection of orphans and vulnerable children (OVC) and families to reduce the burden of HIV/AIDS. Based on lessons learned, the Avert project has integrated the OVC component in the adult care program.

Activities and Expected Results

ACTIVITY 1: Integrating OVC Components into the Adult Care Programs

The Avert project is supporting nine nongovernmental organizations (NGOs) (four in Avert priority districts and five in MSACS districts) that have integrated OVC into adult care services. The purpose of implementing OVC activities in Maharashtra State AIDS Control Society (MSACS) districts is to build the capacity of the technical officers in the MSACS through joint monitoring and on-site mentoring.

Based on the experience of implementing separate OVC programs, Avert project found out that it was not cost-effective to support an NGO for only OVC activities as the number of OVC children on an average was 50 to 75 per district. Moreover, Avert project found that in a community-based family-centered approach, both the adult care and the OVC NGOs were reaching the same families in providing the care services. Hence, the OVC component was added to adult care program with addition of two staff (life skills education teacher and a nurse). In addition, the adult care providers were also trained on OVC activities such as counseling, medical care, referral support and documentation. The integration has saved $330,000 that would have been paid for staffing, rent and infrastructure if we had funded separately nine OVC NGOs.

As part of the OVC program, weekly medical clinic is organized at the NGO office. At the clinic, the medical doctor screens and provides treatment for opportunistic infections; conducts nutritional assessment and OVC children with <18 body mass index (BMI) is provided therapeutic supplementation until normalcy; and also refers to ART center for higher level care. Cooking demonstration using locally available foods is conducted for the family members of OVC. A life skills training is carried out for OVC children using the Family Health International (FHI) life skills tool kit. The NGO also advocates with the schools to enroll OVC children and provides follow-up support such as assistance in learning and provision of free study materials.

Currently, the Avert project is providing services to 1,500 OVC and plans to reach another 3,000 OVC in FY09. In FY09, a mapping of OVC will be conducted with technical support from the national OVC technical resource group. Accordingly, the program will be scaled-up to reach the new number. The Avert project will train the NGO staff in OVC strategies to provide a minimum standard of care for OVC children. In addition, Avert project will train 30 care givers from the families of OVC children.

Avert project will also provide outreach services and travel support to assist HIV-infected children in accessing ART services. Linkages will be established with educational institutions, child survival

programs, orphanages, nutritional programs and other social support programs to leverage the various services.

In FY10, Avert project will conduct an evaluation and transition nine integrated adult care and OVC programs to MSACS. The Technical Support Unit will assist MSACS in establishing systems to absorb the nine care programs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	408,045	

Narrative:

SUMMARY

Under the National AIDS Control Program Phase III (NACP III), HIV counseling and testing (CT) services have been rapidly scaled-up through out the country. In Maharashtra State, 604 integrated counseling and testing centers (ICTC) have been established in high prevalence districts expanding to all community health centers (CHCs). In addition, ICTC services have been initiated in 152 twenty four-hour primary health centers (PHCs) and 56 ICTC centers were established in the private sector to improve accessibility to most-at-risk-populations (MARPs). Based on request from the National AIDS Control Organization (NACO), the Avert project is demonstrating the link workers program to increase the uptake of ICTC services by mobilizing the MARPs and vulnerable populations using a variety of approaches. The Link Worker Scheme is an outreach strategy in the NACP-III aimed at generating a cadre of trained local personnel ("link workers") to work with MARPs and vulnerable populations, in the rural areas of high burden A and B categorized districts. The Technical Support Unit (TSU) of the Avert project provides technical assistance to the Maharashtra State AIDS Control Society (MSACS) in planning, implementing and monitoring the private sector ICTC services.

Migrants have difficulty accessing the existing health services. There are several factors such as culture, language and being an outsider and not having local identity, that act as barriers to access the ICTC services. NACO aims to test and counsel 80% of migrants reached through prevention programs. Hence, NACO recommended that Avert project pilots a mobile ICTC program for migrant populations, document the lessons learned and assist the national program in designing policies and plans for CT services for migrants country-wide. The mobile ICTC clinics will be scheduled at timings and at sites convenient to the migrant populations.

ACTIVITIES AND EXPECTED RESULTS

ACTIVITY 1: Community Mobilization to Improve Access to CT Services

In FY08, the Avert project with USG funds initiated a Link Worker Program in five high prevalence districts to improve access to prevention, testing care and treatment services for MARPs and vulnerable populations in rural areas. In addition, NACO has selected Avert project to implement the Link Worker Program in 21 high prevalence districts with funding from Global Fund Round Seven. The Avert project will select 21 nongovernmental organizations (NGOs) and build their capacity to manage the Link Worker Program. As a first step, the Avert project will conduct a needs assessment of the district including mapping, to identify 100 high-risk villages based on selected criteria (such as number of positive people, number of MARPs etc.) in line with the link workers guidelines. The aim is to demonstrate the best practices in implementing the Link Worker Program. One of the key strategies of the Link Worker Program is to mobilize MARPs including vulnerable populations to access ICTC services, and to link those who test positive with care and treatment services. The Link Worker Program will network with prevention NGOs for MARPs for linkages to ICTC services. In FY 09 and continuing in FY10, Avert project will strengthen the link workers activities. The link workers will be trained using the standard curriculum developed by NACO. The Link Worker Program will be evaluated and the best practices will be documented and disseminated nationally and internationally including publications in peer reviewed journals.

ACTIVITY 2: Strengthening the CT Services through Mobile ICTCs for Migrants.

The Avert project is piloting six mobile ICTCs in the high prevalence districts of Thane, Aurangabad, Sholapur, Nagpur and Jalna. The district of Thane has the largest concentration of migrants with over 600,000 working in the textile industries. A Technical Resource Group formed for migrant interventions will provide ongoing technical assistance (TA) to strengthen the quality of the ICTC services. The activities of the mobile ICTCs include counseling and testing, STI treatment, TB screening and distribution of information education and communication (IEC) materials. Rapid tests are carried out using the NACO protocol. The testing kits for the mobile ICTC program are leveraged from the MSACS. The mobile ICTC team comprises of two part-time medical officers, two nurses cum counselors and one lab technician. A monitoring system is put in place to track the progress including quality of services. To ensure quality of HIV testing the mobile ICTCs will be linked to the External Quality Assessment Scheme (EQAS) implemented in Maharashtra State. Migrants testing positive will be linked to care and treatment services in the districts. Generally, the migrants stay for a period of three to six months depending upon the nature of occupation. In this context, it is a challenge to provide care and support services when they go back to their villages. The Avert project will take efforts to link the HIV positive migrants to positive networks in their respective states. In FY 10, Avert project will evaluate the effectiveness of the mobile ICTC services, document the best practices and challenges and disseminate at the national and

international level including publications in peer reviewed journals. A transition plan will be drawn to transfer the mobile ICTCs to the MSACS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	310,248	

Narrative:

SUMMARY

As FY10 will be the last year of the current Avert project, the project will support evaluation of various programs including prevention programs for most-at-risk-populations (MARPs), workplace interventions and community mobilization programs. In addition, the Avert project will support Maharashtra State AIDS Control Society (MSACS) in conducting data triangulation, correlation and trend analyses of state-level data and collation and analyses of district-level programs. The findings of the evaluation and various state level analyses will feed into the design process of any follow-on assistance provided by USG. The Avert project will also support MSACS in conducting evidence-based planning for the state and disseminating the results at state and national levels.

ACTIVITIES AND EXPECTED RESULTS

ACTIVITY 1: Evaluation of Prevention Programs for MARPs

USG will conduct a final evaluation of the prevention programs for the MARPs. The evaluation will address the following questions:

1. Have the prevention programs saturated coverage of MARPs? Have they led to the reduction of HIV prevalence in the districts?
2. How effectively were the prevention strategies for MARPs implemented, including the systems established to monitor the quality of the programs?
3. What were the lessons learned and challenges in implementing the prevention programs among MARPs?

USG will hire a team comprising of international and local experts to conduct the evaluation. The findings of the evaluation will be disseminated at state and national level. In addition, scientific articles on the evaluation findings will be submitted for publication.

ACTIVITY 2: Evaluation of Link Workers Program in Mobilizing Community to Access HIV Services

The Link Worker Program implemented by the Avert project in 25 districts of Maharashtra State will be evaluated - to assess the effectiveness of the various community mobilization strategies to increase the uptake of HIV services. These include prevention, counseling and testing, care and support and ART; the cost-effectiveness of this program and the feasibility of integrating these services into general health services of Maharashtra Government. USG will hire a team comprising of international and local experts to conduct the evaluation. The findings of the evaluation will be disseminated at state and national level. In addition, scientific articles on the evaluation findings will be submitted for publication.

ACTIVITY 3: Evaluation of Integrated Adult Care and Support and HIV Care for Orphan and Vulnerable Children

In FY08, the Avert project initiated the integrated adult care and OVC program in five high prevalence districts. This was based on the lesson learned that, in a concentrated epidemic, it is not cost-effective to implement separate care and support programs for adults and OVC. USG will hire a team comprising of international and local experts to conduct the evaluation. The findings of the evaluation will be disseminated at state and national level. In addition, scientific articles on the evaluation findings will be submitted for publication.

ACTIVITY 4: Evaluation of the Technical Support Unit (TSU) Program

In FY10, the USG funded TSU will complete three years of supporting MSACS in establishing systems to scale-up and to strengthen the quality of prevention programs including public-private-partnerships in counseling and testing and STI services. The USG will hire a team of experts to evaluate the effectiveness of the TSU. The key evaluation questions are:

1. Has the TSU established systems and built the capacity of MSACS in grants management, monitoring and evaluation and training of NGOs?
2. How effective is the role of the TSU in strengthening the District AIDS Prevention Control Units (DAPCUs) to integrate HIV/AIDS programs in the general health services of Maharashtra Government?
3. Has the TSU transferred the skills to MSACS for designing and managing public-private-partnerships in HIV/AIDS?

ACTIVITY 5: Behavioral Surveillance Survey (BSS) Round Six

In FY10, the BSS Round Six (rural and urban) will be undertaken by the Avert project based on the request from State AIDS Control Society (SACS) and covering a large number of groups– MARP, bridge population and general population (male/female, youth/adults). The BSS captures the behavioral trends among the MARPs and migrant populations on specific indicators such as consistent condom usage, STI

treatment seeking behavior, reduction in multiple partners and HIV testing. The aim of the survey is to assess the impact of prevention programs through the targeted intervention approach for MARPs in urban areas and prevention programs through Link Workers reaching the high-risk populations in the rural areas. The BSS findings will also feed into the evaluation program planned for MARPs. The survey will be undertaken by an external research agency and will be monitored by the technical advisory group of the Avert project.

ACTIVITY 6: Data Triangulation and Analyses

In FY08 and continuing in FY09, the Avert project in collaboration with the Biostatistics Department of the Christian Medical College, Vellore is supporting the state in conducting the triangulation of data to assess the impact of programs, identify programmatic gaps and strengthen policies and programs. In FY10, the focus of data triangulation will be at district-level to better understand the local HIV epidemic and conduct micro-planning to sharpen the focus of the programs. The sources of data will be BSS, data from HIV services (CT, PMTCT, ART) and NGO programs. An overarching approach in conducting the data triangulation is to engage biostatisticians and program officers from the state (MSACS and DAPCU) and build their capacity through hands-on experience. The findings from triangulation and other analysis will be disseminated and sent for publications in peer reviewed journals.

ACTIVITY 7: A Study to Explore Issues of Family Members as Care Givers for PLHIV

NACP III has identified the need to have a community and family-based response in care and support to PLHIV, and hence proposes a shift from provider-centered to family-centered care. The study aims to understand the profile of family care providers, the dynamics within families due to HIV and their needs with regard to providing care and support to PLHIV. The Avert project will hire qualitative experts to conduct the study and the findings will be disseminated at state and national level. The findings will be utilized to design family care-centered strategies, including developing training modules for family care providers.

ACTIVITY 8: Impact Assessment of District Communication Plan

In FY08 and continuing in FY09, the Avert project with technical support from Johns Hopkins University (JHU) had developed district communication plans in the five high prevalence districts. The key strategy of the district communication plan includes the engagement of the entire district health system in implementing of the communication plan. A baseline survey will be conducted prior to implementation of the plan, and an evaluation is planned in FY10 to assess the effectiveness of the district communication approach.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	218,020	

Narrative:

SUMMARY

The Avert project plays a critical role in strengthening the health systems activities of the State AIDS Control Societies (SACS) of Maharashtra and Goa States. As requested by the National AIDS Control Organization (NACO), the Avert project established the Technical Support Unit (TSU) in April 2008. The TSU plays a significant role in assisting the SACS to scale-up and improve the quality of HIV/AIDS programs in the two states. NACO has requested the USG to strengthen the District AIDS Prevention Control Unit (DAPCU) in its focus states. While the SACS continue to lead the planning, coordination and monitoring of activities in the states, the DAPCUs are being established to serve as the nodal agencies at the district level to coordinate the HIV/AIDS activities as well as to promote integration with National Rural Health Mission (NRHM). The TSU is tasked to develop a strategic plan in consultations with the SACS to strengthen the DAPCU to achieve the long-term vision of the NACO to integrate with the NRHM by 2012. The Government of India established the NRHM in 2005 with the aim of providing effective health care to rural populations in 18 backward states which have weak public health indicators and weak infrastructure.

ACTIVITIES AND EXPECTED RESULTS

ACTIVITY 1: Capacity Building of SACS through TSU

By FY10, the TSU aims to strengthen the systems within the SACS for supporting a sustained response in HIV prevention services. While the SACS is responsible for making grants to non-governmental (NGO) and community-based organizations (CBOs) to implement programs, the TSUs provide strategic and technical assistance and oversight, and lead technical assistance (TA) on critical thematic areas of strategic program management, targeted interventions, capacity building of NGOs/CBOs, mainstreaming and public-private partnerships.

The Avert TSU has played a significant role in assisting the SACS to scale-up and strengthen 84 targeted intervention programs in Maharashtra and 19 in Goa; 60 public-private-partnerships in integrated counseling and testing services; and 1260 sexually transmitted infections (STI) franchising clinics in Maharashtra. One of the key STI strategies of NACO is to partner with preferred private health care providers to provide STI services to MARPS through a franchising approach at district and sub-district levels.

TSUs are assisting the SACS in conducting task analyses, identifying training needs, developing curricula, planning training logistics and implementation, and monitoring and evaluating the quality of training programs. The TSUs have assisted the SACS in developing training plans and conducting training programs for the newly identified targeted intervention NGOs working on prevention for MARPs. For example, the TSU has assisted the SACS in conducting training for NGOs on proposal development, induction training for new NGO staff, and training doctors in STI management, training various cadres of government health workers in order to integrate HIV services in NRHM. In FY08, 1,054 NGO staff in Maharashtra and 150 NGO staff in Goa were trained with TA provided by the TSU. In FY10, Avert project will conduct an evaluation of the effectiveness of TSU (See 17-HVSI Strategic Information for details).

ACTIVITY 2: Technical Support to Strengthen DAPCU

Based on NACO's recommendation, the TSU has developed a plan in consultation with MSACS to strengthen the capacity of the DAPCU in 33 high prevalence districts. Specifically, DAPCU's capacity will be strengthened to coordinate HIV/AIDS programs of the district-level and to integrate HIV services such as STI treatment, counseling and testing and PMTCT into the general health services of Maharashtra Government. The DAPCU team comprises of a District Program Officer, Monitoring & Evaluation officer and Accountant. The TSU will provide technical support to build management and technical capacity of DAPCUs with a focus on program management, coordination and strategic information. To implement this initiative, the TSU has developed a resource pool of 150 consultants to provide ongoing support to the DAPCUs in implementing coordination and integration activities.

ACTIVITY 3: Building State Capacity to Implement a Systems Approach to Curriculum Development and Training

In line with the national agenda, MSACS with support from the TSU has intensified training efforts by identifying a pool of training institutions across the state to deliver technical (prevention, care and treatment) and management training programs to various cadres of NGO and public and private sector staff providing HIV/AIDS services.

A major concern in human capacity building is the lack of competency among training personnel to conduct trainings using scientific approaches including adult learning principles. The TSUs have been mandated to fill this void and support the capacity building efforts of the SACS following a systems approach to curriculum development and training. The TSU in collaboration with the RUHSA (Rural Unit for Health and Social Affairs) Department of Christian Medical College, Vellore, conducted a training of trainers (TOT) training on a Systems Approach to Curriculum Development and Participatory Training

Methods. The TSU with technical support from RUHSA will develop a strategic plan to build the capacity of health care and development institutions; capacity-building managers in government and private health institutions, and a large pool of resource persons at state, district and sub-district level. The vision is to develop a culture of adopting a systems approach to curriculum development and training in the state. The best practices of this initiative will be documented and replicated at the national level.

ACTIVITY 4: Provision of In-Service Training

As part of the in-service training program, in FY10, Avert project will conduct a range of the training programs for the outreach team of the NGOs based on the needs identified through task-analysis methods. Avert project will collaborate with the training institutions to train 117 peer educators, 73 project coordinators, 110 counselors, 292 outreach workers, 73 accountants, 30 care providers and 160 link workers. The training programs will be based on the modules developed in consultation with Avert project following systems approach to curriculum development and in-line with the NACO guidelines. The topics include peer development, basic facts in STI/HIV/AIDS, counseling, management information system, care & support and accounts.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	892,962	

Narrative:

SUMMARY

The Avert project is implementing prevention activities among most-at-risk populations (MARPs) in five high prevalence districts (Aurangabad, Jalna, Nagpur, Sholapur and Thane) of Maharashtra State. By 2011, Avert project aims to bring down the prevalence from 1% (average of five districts) to less than 0.5% by saturating the coverage and improving the quality of services among MARPs. An epidemiological analysis carried out using Behavioral Surveillance Survey (BSS) and HIV prevalence data showed that a 10% increase in consistent condom usage among female sex workers (FSW) and men who have sex with men (MSM) will lead to a reduction of 0.1% HIV in prevalence among general population.

The Avert project has reached 80% of the estimated 15,000 FSW and 65% of the 17,500 MSM populations with prevention services. The HIV prevalence among FSW in Maharashtra is 17.9% and among MSM 11.9% (Sentinel Surveillance, 2007). Based on the evidence from migrant studies in India, the National AIDS Control Organization (NACO) has identified migrants as an important driver of the HIV/AIDS epidemic. To date, there are no well developed models for migrant interventions in India. To

support national efforts in designing migrant strategies, the Avert project has initiated demonstration programs among certain migrant groups who are at greater risk of HIV/AIDS, e.g. those working in textile, construction and sugarcane industries. The Johns Hopkins University (JHU) is supporting the Avert project in designing demand generation campaigns tailored to MARPs. Similarly, Hindustan Latex Family Planning Promotion Trust (HLFPPT) is providing technical support to integrate the condom social marketing program into the MARP interventions. To design and strengthen workplace intervention programs, Avert project is seeking technical assistance (TA) from the International Labor Organization (ILO).

Previously, Avert project supported a large number of nongovernmental organizations (NGOs) to implement prevention activities with MARPs. In line with PEPFAR India vision, the USG HIV/AIDS program, starting from FY09 and continuing in FY10 the Avert project will transition from a direct implementation to a TA program.

In FY 10, Avert prevention activities will focus on the following six key areas; (a) developing learning sites for FSW and MSM interventions; (b) demonstrating models for prevention for migrant populations; (c) demonstrating models for workplace interventions; (d) addressing gender concerns in prevention activities for MARPs; (e) transferring Avert-funded NGOs to Maharashtra State AIDS Control Society (MSACS); and (f) documentation and dissemination.

ACTIVITES AND KEY RESULTS

ACTIVITY 1: Developing learning sites (LS) for FSW and MSM interventions

In FY10, the Avert project will develop two FSW LSs -one brothel-based and one non-brothel based- and one MSM learning site. These LSs are intended to demonstrate best practices in prevention for replication in Maharashtra and Goa States. The brothel and non-brothel based FSW have different community structures. The Nagpur District has a large brothel of over 4,000 FSWs and Aurangabad District has over 4,000 non-brothel based FSWs. Based on lessons learned, the prevention strategies have been revised to suit the context and the needs of these two types of FSWs. Similarly, the Avert project is supporting a well established CBO reaching over 10,000 MSMs in Thane District, and the program in this district will be developed as a MSM learning site. A multi-disciplinary team comprising of a behavioral scientist, bio-statistician and a management expert will be put in place to guide the development of the learning site. In addition, the staffing of the NGOs and the Avert project will be augmented to develop and manage the learning sites for MARPs.

An overarching strategy of the prevention programs adopted by the Avert project is to develop

partnerships with the existing community groups and engage them in planning and monitoring the interventions. In line with the national strategy, Avert project has adopted a comprehensive prevention approach such as behavior change interventions; sexual transmitted infection (STI) services tailored to MARPs (over 80% treated); structural interventions to address violence and coercion; legal aid and linkages to social development programs; and referral linkages to counseling and testing (CT) and care and treatment services.

The behavior change interventions are carried out by a strong network of peer educators who are trained on interpersonal communication skills, development of self esteem, STI identification; micro-planning and monitoring following nationally approved training curricula. The peer educator on an average conducts five to seven sessions per FSW with each session lasting one hour in a week. The peer educators are trained to conduct street plays, puppet shows and games related to MARPs. In addition, the peer educators promote condoms (male and female); provide accompanied referral services to FSW on STI, CT and care and treatment and document the activities. JHU has developed a set of innovative materials for outreach workers and the peer educators including street play scripts to conduct behavior change interventions with MARPs. The picture and color coded monitoring tools developed by Bill and Melinda Gates Foundation (BMGF) for peer educators to monitor and record activities are adopted by the Avert project.

HLFPPT provides condom social marketing support by establishing condom outlets that are easily accessible to MARPs and their clients. In addition, free condoms are distributed by the peer educators to FSWs and MSMs to ensure that condoms are available at all times to negotiate use with clients.

The Avert project has developed referral systems for CT and care and treatment services, to ensure that over 80% of MARPs are counseled and tested, and those tested positive have access to ART services. The Avert project will also develop a network of positive MARPs groups which will implement positive prevention programs including linkages to care and treatment services.

In FY09, the Avert project is planning to integrate research and evaluation into the MARP intervention to test the efficacy of the prevention strategies. The research will answer reasons of non-coverage of MARPs including accessibility to services. Avert project will also strengthen the monitoring and evaluation (M&E) system including data management system and enhance the capacity of the staff in conducting evaluation, analysis and dissemination.

ACTIVITY 2: Demonstrating Models on Migrant Interventions

Maharashtra is an industrial state that attracts a large number of migrant workers from different parts of

the country. The majority of the migrants come from the states of Uttar Pradesh (27 percent), Karnataka (19 percent), Gujarat (10 percent), Madhya Pradesh (10 percent), and Andhra Pradesh (7 percent). It is estimated that there are over 6.2 million migrants (census report, 2001) and of these 1 million are vulnerable to HIV (estimate based on Pop Council Study) in the five Avert priority districts. The migrant types are linked to the nature of industries. For example, textile industries have predominantly single male migrants while the sugar cane and brick making industries have family migrants. In FY08, Avert project had initiated 24 interventions among migrants in the textile, brick making and small scale industries. From among these interventions, the Avert project is planning to develop three models on migrant interventions among textile, brick making and selected small scale industries that are at risk to HIV. The Avert project is establishing a technical resource group comprising experts in migrant research and programs to guide the design, implementation, M&E and research. The behavior change communication (BCC) approaches are tailored to the migrant subcultures and includes advocacy with management, peer-led group sessions and community media activities such as street play, puppet shows and games. The peer educators are trained in interpersonal communication skills, basic facts on HIV/AIDS, condom promotion and referral services using a standard curriculum. The peer educators conduct three group sessions of one hour each for their unit of workers in a week. The peer educators will monitor the activities using a simplified tool that are color and picture coded. Avert project is implementing a mobile STI and CT services for the migrant populations (details provided in 14 HVCT) and those testing positive will be supported with accompanied referrals to care and treatment services including motivating them to join the people living with HIV/AIDS (PLHIV) network. The adult care and support strategy envisages networking between MARP NGOs and the care and treatment programs to facilitate HIV care services to MARPs. Avert project will also conduct operational research studies in behavioral intervention models and improving access to HIV services. In FY10, Avert project will document the best practices, disseminate to NACO and provide technical support in developing policies and guidelines for national level scale-up.

ACTIVITY 3: Demonstrating Models on Workplace Interventions

In FY09, the Avert project with technical assistance (TA) from the International Labor Organization (ILO) will conduct a study to identify industrial sectors vulnerable to HIV in the five industrial zones located in Nagpur, Nasik, Thane, Mumbai and Pune (Pop Council, 2008). In addition, the Avert project will also conduct a study to assess the vulnerability of the workers in the sugarcane industry in the sugar cane belt comprising of Sangli, Satara and Kolhapur districts. Based on the findings of the two studies, Avert project will prioritize vulnerable sectors in the five districts and a baseline behavioral survey among workers will be conducted. Avert project will select lead NGOs in these districts to implement a comprehensive workplace intervention program with technical support from ILO. JHU will develop

communication materials including workplace intervention campaigns tailored to the context and the vulnerability to HIV/AIDS of different sectors. The BCC approaches in workplace intervention includes advocacy with senior management, peer-led interpersonal communication activities and small media activities such as street plays and exhibitions. Motivated peer educators from the different units of an industry will be identified and trained using standard curricula. The Avert project will also advocate with the industries to develop HIV/AIDS workplace policies to support prevention, care and treatment services. The Avert project will adopt various strategies to provide CT services to most-at-risk workers including organizing mobile testing services and providing accompanied referrals to CT centers in public and private sectors. Networking between workplace intervention and care and support NGOs including PLHIV networks will be conducted to facilitate HIV care services to workers tested positive. A monitoring and evaluation system including a robust management information system (MIS) will be developed to assess progress and to identify gaps and strengthen the interventions. In FY10, the demonstration programs will be continued and an evaluation will be conducted to assess the outcomes of the workplace intervention program. Avert project with technical support from ILO will document the best practices and will disseminate them to a variety of stakeholders including National AIDS Control Organization (NACO), Ministry of Labor and Ministry of Industries. In addition, a national policy and operational guidelines will be developed for replication in other states.

ACTIVITY 4: Programs to Address Gender Concerns

The key strategy of Avert project is to mainstream gender activities in the prevention, care and support programs implemented by NGOs. In the FSW intervention, the strategies included formation of crisis groups to address violence and coercion by police and clients, legal aid and advocacy with the police. In the migrant intervention programs, gender strategies will focus on addressing sexual exploitation of women by labor contractors. The technical capacity of the Avert project to carry out gender programming is not strong. Hence, Avert project will seek technical assistance from the USG PEPFAR Gender Technical Working Group (TWG) at headquarters who will collaborate with local gender experts for strengthening the gender activities including developing guidelines, training modules and monitoring tools. In FY10, an evaluation of HIV/AIDS gender programming will be conducted through gender audit, the best practices will be documented and dissemination will be carried out nationally. Avert project will support USG in providing technical assistance (TA) to NACO in developing policies and guidelines to address gender concerns for MARPs.

ACTIVITY 5: Transfer of NGOs to MSACS

The second phase of the Avert project will end in June 2011. In anticipation of the project ending, the Avert project is gradually transitioning from direct implementation to a TA mode. An evaluation of the

Avert project will be conducted in 2011 (details in HSS budget code narrative). As part of these transition efforts, the Avert project will plan with MSACS and NACO to transfer 25% of grants (20) in FY09 and 75% of grants (40) in FY10 to government funding. The Technical Support Unit (TSU) will support the Avert project in transferring the grants including strengthening the systems at the MSACS and district AIDS prevention control units (DAPCU) to manage the additional burden. ACTIVITY 6: Documentation and Dissemination: Avert project will hire experts to document the best practices of the demonstration programs on migrants and workplace interventions. In addition, articles will be written and sent to peer-reviewed journals for publication.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10982	**Mechanism Name: DOD**
Funding Agency: U.S. Department of Defense	Procurement Type: Grant
Prime Partner Name: US Department of Defense	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 582,195	
Funding Source	**Funding Amount**
GHCS (State)	582,195

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Department of Defense (DOD) has worked with the Indian Armed Forces Medical Services (AFMS) since 2004 to strengthen the AFMS's existing program that provides HIV/AIDS prevention, care and treatment services to military personnel and their families. As with many militaries worldwide, the Indian Armed Forces personnel are an at-risk population since soldiers are generally young, mobile, separated from their families, and exposed to commercial sex workers. With a troop strength of nearly1.3 million,

troop turnover, and an annual recruitment of 80,000 new recruits and their accompanying family dependents who are new to the military community, it is critical for the AFMS to develop a sustained HIV prevention, care and treatment program which can be accessed by military personnel and their families.

Key Ongoing Activities:
? HIV Education Program - AFMS supports an education program that trains peer leaders and counselors and produces and distributes IEC materials. Master Peer Leader Educators are trained through Train the Trainer workshops. They then train additional peer educators reaching at least 30,000 soldiers, dependents, and civilians through a "cascade" process. IEC materials are used in conjunction with counseling and discussion of life skills, including the importance of abstinence and/or fidelity, addressing gender stereotypes, male norms and behaviors, reduction in violence as well as stigma and discrimination. Modules. These materials are expected to reach over 40,000 soldiers through 93 IEC nodes as well as through peer educators and Integrated Counseling and Testing Centers. The IEC and training materials are military specific and conform to national guidelines.
? HIV/AIDS Treatment and Care Workshops for Healthcare Providers – The AFMS has an on-going treatment and care program. The DOD supports four-day workshops for health professionals that focus on recent trends in prevention and treatment strategies for HIV patients in the civilian and military sectors. DOD also supports procurement of disposable medical supplies, including CD4 and Opportunistic Infection kits, so providers will have critical medical supplies for patient treatment and care.
? Laboratory Equipment and Maintenance – The DOD supported AFMS by providing CD4 machines and testing equipment. Currently, DOD collaborates with AFMS to keep the equipment operating at full capacity, with a goal to transfer the titles of all equipment to AFMS. DOD will procure items such as FACS Count Reagent Kits and other disposable supplies required for continued equipment operation.
? Integrated Counseling and Testing Centers (ICTCs) – AFMS is in the process of mainstreaming support for staff in their ICTCs. Initially established with support from NACO, the AFMS plans to initiate a limited expansion of these centers and assume the costs of training and supporting their staff. DOD will collaborate with AFMS to support these centers through a cost-sharing process as they transition to being fully integrated in the AFMS system.
? Monitoring and Reporting – these ongoing activities will measure the impact of various prevention, care and treatment interventions conducted over the past three years and will awareness of and commitment to the importance of regular data collection, monitoring, reporting, and evidence-based planning.

Project Achievements and Innovations:
? Upgrading of key AFMS laboratories through provision of machines and test kits to expand HIV testing, clinical diagnosis of HIV/AIDS, and assessments to facilitate ongoing treatment of HIV positives
? Collaboration to support production of IEC materials and training for the AFMS's HIV training program that reaches around 40,000 troops and their families each year

? Support for military-to-military exchange through participation of AFMS staff in regional and global workshops and conferences on HIV/AIDS
? A significant innovation is the ongoing mainstreaming of Integrated Counseling and Testing Centers into the regular services of the AFMS. Under this system, the ICTCs will continue to be staffed by civilian counselors and laboratory technicians, who will be trained and supported directly through the AFMS.

Cross-Cutting Budget Attribution(s)

Education	70,000
Human Resources for Health	142,000

Key Issues

Military Population

Budget Code Information

Mechanism ID:	**10982**
Mechanism Name:	**DOD**
Prime Partner Name:	**US Department of Defense**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	32,500	

Narrative:

CONTINUING ACTIVITY - NEW ACTIVITY NARRATIVE

SUMMARY
Activities under Adult Care focus on strengthening the human resource capacity of the Indian Armed Forces Medical Services (AFMS) to provide a high quality of health care and support to HIV-positive soldiers and to ensure that the AFMS has the critical medical supplies available while providing care and treatment services. These activities are a continuing collaboration between the US Department of Defense (DOD) and the AFMS to improve the human capacity to address HIV care and treatment at military medical facilities and ensure the availability of key medical supplies. DOD will continue to work closely with the Indian AFMS to improve and enhance the skills of healthcare providers, (including

doctors) to manage, care, treat, and monitor HIV patients who are on antiretroviral treatment (ARV). DOD will procure medical supplies in consultation with AFMS.

ACTIVITIES AND EXPECTED RESULTS
The goal of the training workshops in treatment, care and support is to build the human resource capacity of military medical officers, nurses, and paramilitary medical personnel so that they are better able to care for and treat HIV-positive military staff and their families. Past HIV care and treatment workshops focused on topics that included medical adherence, post diagnosis counseling and psychological support.

ACTIVITY 1: HIV/AIDS Treatment and Care Workshop for Healthcare Providers
AFMS will continue to develop, refine, and implement the HIV care and treatment trainings. Two training workshops will be executed. These four-day workshops will focus on recent trends in prevention and treatment strategies for HIV patients in the civilian and military sectors. As in previous training, workshops program will includes sessions on "Antiretroviral Therapy Case Studies," "Monitoring Antiretroviral Therapy: Practices and Problems, " "Emerging Toxicity Syndromes in HIV in HIV Infection, " "Recent Concepts in Drug Resistance and Strategies to Maximize Drug Compliance." Building on past workshops, with FY09 funds, AFMS plans to carry out similar workshops for healthcare providers who did not attend the previous two workshops. At least 60 military medical providers will be trained.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	67,500	

Narrative:

CONTINUING ACTIVITY - NEW ACTIVITY NARRATIVE

SUMMARY
Activities under Adult Treatment focus on strengthening the human resource capacity of the Indian Armed Forces Medical Services (AFMS) to provide a high quality of treatment to HIV-positive soldiers and to ensure that the AFMS has the critical medical supplies available while providing treatment and care services. These activities are a continuing collaboration between the US Department of Defense (DOD) and the AFMS to improve the human capacity to address HIV care and treatment at military medical facilities and ensuring the availability of key medical supplies. DOD will continue to work closely with the Indian AFMS to improve and enhance the skills of healthcare providers, including doctors, to manage, care, treat, and monitor HIV patients who are on antiretroviral treatment (ARV). DOD will procure the medical supplies in consultation with AFMS.

ACTIVITIES AND EXPECTED RESULTS

This activity area supports the training workshops in treatment, care and support that will be carried out by the AFMS. The purpose is to build the human resource capacity of military medical officers, nurses, and paramilitary medical personnel so that they are better able to treat and care for HIV-positive military staff and their families.

ACTIVITY 1: HIV/AIDS Treatment and Care Workshop for Healthcare Providers
AFMS will continue to develop, refine, and implement the HIV care and treatment trainings. Two training workshops will be executed. These four-day workshops will focus on recent trends in prevention and treatment strategies for HIV patients in the civilian and military sectors. As in previous training, workshops program will includes sessions on "Antiretroviral Therapy Case Studies," "Monitoring Antiretroviral Therapy: Practices and Problems, " "Emerging Toxicity Syndromes in HIV in HIV Infection, " "Recent Concepts in Drug Resistance and Strategies to Maximize Drug Compliance." Building on past workshops, with FY09 funds, AFMS plans to carry out similar workshops for healthcare providers who did not attend the previous two workshops. At least 60 military medical providers will be trained.

ACTIVITY2: Procurement of Disposable Medical Supplies for AFMS Medical Facilities
In consultation and coordination with the AFMS, the ODC will facilitate the procurement of disposable medical supplies, including CD4 and Opportunistic Infection kits so providers will have critical medical supplies for patient treatment and care. Once procured, the medical supplies will be given to the AFMS to distribute to military medical facilities. AFMS will report on the military medical facilities that benefit from the supplies and on usage. Funds will also support technical support and travel as required. At least four military medical facilities will benefit from these supplies.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	249,500	

Narrative:

CONTINUING ACTIVITY - NEW ACTIVITY NARRATIVE

SUMMARY
DOD will continue to support VCT training for HIV counselors and procurement of HIV test kits and other disposal medical supplies. The COP will also support a new VCT activity: funding will be provided to the Armed Forces Medical Service (AFMS) to assist in maintaining and expanding its Integrated Counseling and Testing Centers (ICTCs). Support for the ICTCs will bridge the budget gap until AFMS can fully finance these centers in FY 2013; support will help to offset the costs of limited expansion of the ICTCs to key military service hospitals.

ACTIVITIES AND EXPECTED RESULTS

AFMS has conducted several successful counseling workshops, supported by PEPFAR. Over 185 military personnel and civilian staff serving the military community have been trained. As military staff is mobile and routinely reassigned, continued training is required to build the skills of new personnel, and in some cases to refresh the knowledge base of others. DOD in consultation with the AFMS, the US Embassy/Office of Defense Cooperation (ODC) in New Delhi has procured test kits and other medical supplies in previous years with PEPFAR funds. These activities remain an important part of the military to military partnership in the VCT arena and will continue in FY09 and FY10.

Support of AFMS' ICTCs is a new activity. Programming in this area reflects a significant change in the DOD component of PEPFAR COP FY10. COP funding will further develop the human resource capacity of AFMS by training and supporting staff at existing and additional ICTCS. We expect that the 20 existing centers will remain open at full operating capacity and at least 10 new centers will be opened. We expect AFMS to gradually increase its share of funding until it eventually retakes full control by FY 2013.

This increase has been proposed in consultation with AFMS and reflects growth in the program and a plan to eventually transition the program to full ownership by AFMS by FY 2013. In FY09, $220,000 of PEPFAR funds will support training and the ICTCs; $30,000 will be used for the procurement of test kits and other disposable medical supplies. In FY 2010, DOD will propose decreasing the HVCT program area by $50,000 a year until AFMS has full budgetary ownership of its ICTCs in FY 2013. This transition is necessary because MOD's budgeting process has not been responsive enough to respond to this shortfall in the short term. AFMS is confident that the MOD budgeting process will respond according to the new schedule. ICTCs are such a central part of the shared goals of AFMS and PEPFAR that it is essential to keep them developing according to existing plans despite this temporary setback.

ACTIVITY 1: Counseling and Testing In-Service Workshop

AFMS will execute one counseling and testing in-service workshop. As note, military staff is mobile and routinely reassigned, and continued training is required to build the skills of new personnel, and to refresh the knowledge base of others. At least 45 counselors, serving the military community will receive this training.

ACTIVITY 2: Support for Salaries of ICTC Staff

DOD will support ICTC staff with AFMS, through ODC/DOD support to AFMS. Twenty existing ICTCs will be supported and at least 10 more ICTCs will be opened with cost-shared resources.

The request to support the ICTCS is due to a major shift in National AIDS Control Organization (NACO)

funding. NACO previously funded the salaries and training of the AFMS' ICTC staff, however, as part of its drive to mainstream HIV/AIDS program activities within relevant ministries, AFMS no longer receives NACO funds to carry out HIV/AIDS prevention, care, and treatment activities. Consequently, no staff support is provided for the AFMS's ICTCs. The AFMS identified support for the existing ICTCs and the planned expansion of these centers as a priority for developing and maintaining a successful military HIV/AIDS prevention program. Therefore, the DOD PEPFAR program proposes providing significant support to the AFMS to help offset the costs the ICTCs for a limited time. This will allow the ICTCs to continue to provide services at full capacity, as the AFMS develops a plan to fully fund them and initiates a limited expansion of these centers within key military hospitals.

While AFMS will still cover some of the costs of the ICTCs, the increased support is essential in sustaining the present level of service and ability to provide essential HIV testing, counseling and care. Without increasing support, ICTCs will face an uncertain fate, which will significantly setback AFMS' HIV/AIDS program as a whole. ICTCs are often the first step in determining HIV status, receiving and distributing IEC and BCC materials to service members and, as required, linking into AFMS' care and treatment activities. Support and eventual expansion of ICTCs to the military service hospitals will broaden access to voluntary counseling and testing (VCT) while also increasing demand for and awareness of HIV/AIDS prevention. These activities contribute to PEPFAR goals by improving access to and quality of VCT services in order to identify HIV-positive persons, increasing the number of health care workers trained in the provision of Parent Mother to Child Transmission (PMTCT) services, increasing the number of service outlets providing HIV-related care and support, increasing the number of individuals who receive counseling and testing for HIV, increasing the number of individuals trained in counseling and testing, and strengthening the overall heath system of the Indian Armed Forces.

ACTIVITY 3: Procurement of Test Kits and Supplies
DOD will coordinate the procurement of rapid test kits and medical supplies; AFMS will receive the medical supplies and distribute throughout the military health care system. At least, eight military facilities will receive test kits and supplies.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	17,695	

Narrative:

NEW ACTIVITY NARRATIVE: CONTINUING ACTIVITY

SUMMARY
The objectives of this activity are to monitor and assess the effectiveness of the ongoing military

HIV/AIDS prevention program, identify areas requiring additional support and greater attention by the Armed Forces Medical Service (AFMS) to improve its data collection and analysis capabilities. Support will be provided for the development, design, and implementation of a further mid-program review. A first mid-program review is currently underway, and its results will inform and guide the development and implementation of this second review, which will be implemented in 2011. Although this is not an annual request, it is anticipated that there will be additional efforts to collect and analyze data regarding the overall DOD PEPFAR India program to ensure that program activities are achieving expected results.

ACTIVITIES AND EXPECTED RESULTS

This activity will allow for a further mid-program review by funding a KAP survey to be implemented in 2011, similar to the one being conducted in late 2008. The results of this review will allow DOD and AFMS to assess the effectiveness of specific DOD PEPFAR/India program activities and help guide future programming. This activity builds upon and further develops AFMS's capacities to monitor, evaluate, and manage information, as well as perform situational analysis and evidence-based planning. These capacities improve health system management, and strengthen information systems and AFMS's overall monitoring and evaluation.

ACTIVITY 1: AFMS Behavioral Survey

In coordination with DOD, AFMS will conduct a behavioral survey aimed at developing the ability to follow health status, knowledge, attitude and practices (KAP). This will be similar to the survey implemented in August 2008, at the time of the review of the PEPFAR program with AFMS. One challenge that this activity faces is the sensitivity of the survey findings. The Indian Armed Forces are not eager to share information concerning their readiness and other related issues for security reasons. This challenge can be overcome through maintaining the strong, trusting relationship with key leaders at AFMS that DOD currently has. Obtaining agreement on how survey data will be released and used prior to survey review will be facilitated by DOD. While these surveys are not an annual request, it is anticipated that they or similar reviews will be used again at some point in the future.

ACTIVITY 2: Monitoring and Reporting

DOD will monitor and report on the implementation of the military component of the PEPFAR program. Some information will be taken from response to the KAP survey which will ask survey participants about IEC materials reach, utilization, comprehension, and peer education sessions. Monitoring and reporting on technical assistance will also be carried out.

Three results are expected from the Strategic Information program component. First, it will help measure the impact of various prevention, care and treatment interventions conducted over the past three years. Second, it will identify areas needing additional support. Finally, it will contribute to the sustainability of

the program by further increasing awareness of and commitment to the importance of regular data collection, monitoring, reporting, and evidence-based planning.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	70,000	

Narrative:

CONTINUING ACTIVITY - NEW ACTIVITY NARRATIVE

SUMMARY

The objective of this activity is to support the Armed Forces Medical Service's (AFMS) expanding HIV/AIDS prevention program. This will be achieved by providing support for the production and distribution of IEC materials for the armed forces and support to the Training of Trainers (TOT) program for secondary school children in Ministry of Defense (MOD) schools. These efforts build on past successes of the production and distribution of IEC material for the armed forces and continue support for HIV/AIDS prevention training for MOD secondary school students. Given the high priority that AFMS places on HIV prevention programs, this activity is a priority for the foreseeable future.

ACTIVITIES AND EXPECTED RESULTS

ACTIVITY 1: TOT program for secondary school children

AFMS will cost share to expand the TOT program to secondary school children in Ministry of Defense (MOD) schools. The life skills TOT program for secondary school children has been developed by AFMS in consultation with MOD school leaders, the National AIDS Control Organization (NACO) and local non-governmental organizations. The curriculum will be based on principles whose efficiency has been proven.

ACTIVITY 2: TOT Peer Education Workshops

Building on the HIV prevention education component for MOD-operated schools (funded by PEPFAR in FY08), AFMS will coordinate and execute TOT workshops designed for adolescents, focusing on life skills, gender stereotypes, and addressing male norms and behaviors to reach a minimum of 500 secondary-school children. In order to reach 500 school children, AFMS will train a minimum of 50 secondary school children to be master peer educators. These 50 master trainers will then train an additional 10 students. This is an activity that has been specifically requested by AFMS. We do not plan to report any targets under this technical area since most of the outreach for this population is with AFMS support and the trainings and materials are co-sponsored by the USG.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	HVOP	105,000	

Narrative:

CONTINUING ACTIVITY - NEW ACTIVITY NARRATIVE

SUMMARY

The objective of this continuing activity is to create a core group of Master Peer Leader Educators whose work spreads HIV/AIDS education within the Indian Armed Forces (IAF) and throughout soldiers' native communities as well. Peer leader education activities extend beyond improved knowledge and awareness to focus on changing norms of male behavior, reducing sexual violence and coercion and decreasing stigmatization and discrimination. This is accomplished through Training of Trainers (TOT) workshops, which will build on the success of workshops held over previous years. These workshops are an essential part of the Armed Forces Medical Service's (AFMS) HIV/AIDS prevention program and the DOD partnership with AFMS, and it is expected that HIV/AIDS peer leader education will continue for the foreseeable future. The activity is linked with the peer leader education activities, the counseling and testing activities, and the adult care and treatment programs and with the training workshops.

ACTIVITIES AND EXPECTED RESULTS

HVOP builds the human resources capacity of AFMS through peer leader education workshops.

This is a continuing activity from FY09 that is being modified as a result of a mid-program review and the pending results of an AFMS knowledge, attitude and practice (KAP) survey. IEC materials will be produced and distributed to support the broader objectives of AFMS's HIV prevention program.

ACTIVITY 1: Production and Distribution of IEC Materials

AFMS has trained and will continue to train peer leaders and counselors who facilitate the dissemination of IEC materials in conjunction with counseling and discussion of life skills, including addressing gender stereotypes, male norms and behaviors, reduction in violence as well as stigma and discrimination. This is an activity that has been specifically requested by AFMS. These materials are expected to reach over 30,000 soldiers through 93 IEC nodes as well as through peer educators and Integrated Counseling and Testing Centers.

AFMS will update the IEC materials based on a curriculum with a proven ability to reach soldiers and their families across India. The program will support the production and distribution of these materials.

ACTIVITY 2: Training of Trainer (TOT) Workshops

The AFMS will execute five TOT workshops that will train over 300 Master Peer Leader Educators. Each

Master Peer Educator will then train an additional 10 peer educators for a total of 3,000 peer educators. This learning will 'cascade' down through the peer leaders reaching at least 30,000 soldiers, dependents, and civilians. The modules and IEC materials for peer leader education trainings are military specific, based on successful materials with proven efficiency and that conform to national guidelines. To support and ensure proper implementation of workshops, AFMS conducts pre and post-workshop knowledge assessments. Workshop participants will be provided with IEC materials to use and distribute when they return to their respective postings and speak on HIV/AIDS. It is expected that these workshops will reach the desired amount of people. Follow-up reviews will inform whether the desired effect of reaching beyond the peer leaders and their peers has been achieved.

Past workshops have included skits performed by local NGOs that demonstrate the roles and responsibilities of peer leaders, visits to local hospitals and clinics, testimonials of People living with HIV and AIDS (PLWHA) to reduce stigmatization and discrimination, practice sessions where peer educators practice being peer leaders, and question and answer sessions where soldiers are given real life choices and decisions facing soldiers and their dependents. Workshops also use videos and media to reinforce key messages and behavioral change objectives.

The workshops are designed to have an impact far beyond their immediate participants. First, those trained as Master Peer Leader Educators are specifically assigned to train 10 others when they return to their bases and these 10 each train another 10. Additionally, HIV/AIDS prevention activities have an all-India impact as soldiers come from all areas of India and are instructed to take Behavioral Change Communication (BCC) messages back to their local communities and villages.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	40,000	

Narrative:

CONTINUING ACTIVITY - NEW ACTIVITY NARRATIVE

SUMMARY

The objective of this program area is to support the Armed Forces Medical Service (AFMS) in maintaining a comprehensive HIV laboratory capability within its health care system. This will be accomplished through the purchase of disposable laboratory supplies such as reagents and maintenance/service support for previously purchased equipment. This will build upon previous success in helping AFMS establish its current level of laboratory capabilities. The program will strive to transfer equipment titles to AFMS and seek alternative support to ensure laboratory maintenance and laboratory supplies.

ACTIVITIES AND EXPECTED RESULTS
The procurement of much needed laboratory equipment and consumables for use in AFMS facilities has continued for several years. This activity has evolved and matured to the point where new equipment is no longer a priority, but maintaining existing equipment is a present challenge because DOD still holds the titles to the laboratory equipment. This prevents AFMS from handling the maintenance itself. (The USG hand-receipt laboratory equipment is housed at AFMS laboratories and is used by AFMS staff in support of HIV/AIDS prevention.)

The biggest challenge this program faces is transferring the titles of previously purchased laboratory equipment to AFMS. There are a number of bureaucratic obstacles to this on both the US and Indian sides. Steps are being taken to remove these obstacles, but until this is done stopgap measures will be required to keep the equipment functioning. Nonetheless, we do anticipate overcoming these obstacles within the next two years for all procured equipment and transitioning this program to full AFMS control, while continuing to fill the gap in needed kits and consumables from PEPFAR funds.

ACTIVITY 1: Procurement
Working in consultation with the AFMS, DOD will procure items such as FACS Count Reagent Kits and other disposable supplies required for continued equipment operation.

ACTIVITY 2: Laboratory Equipment Maintenance
It is expected that this activity will keep all previously purchased equipment operating at full capacity to allow AFMS to maintain the effectiveness of its HIV testing operation.

The long-term goal is to transfer the titles of all equipment to AFMS, but until that time it is crucial that the equipment is maintained and serviced so that the labs remain fully operable. In working to transfer ownership, DOD seeks to ensure that all equipment is in working order. Working in consultation with the AFMS, DOD will procure laboratory equipment maintenance service contracts that will extend the life of previously procured equipment.

AFMS cannot repair or maintain equipment that it does not own due to MOD constraints. Of the requested $40,000, $10,000 will cover the cost of maintenance and $30,000 will go to short-term procurement.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10983	**Mechanism Name: Department of Labor**
Funding Agency: U.S. Department of Labor	Procurement Type: Grant
Prime Partner Name: US Department of Labor	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 294,667	
Funding Source	**Funding Amount**
GHCS (State)	294,667

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Implementing Mechanism Narrative:

ILO is the lead UN agency for HIV/AIDS in the world of work and private sector mobilization. In collaboration with the Ministry of Labour and Employment (MOL&E), National AIDS Control Organization (NACO), Employers' and Workers' Organizations (trade unions), UNAIDS, and People Living with HIV (PLHIV), ILO developed a three-phased program which aims at putting in place a sustainable national program on HIV/AIDS in the world of work in India. The development objective of the ILO program is to contribute to the prevention of HIV/AIDS in the world of work, enhancement of workplace protection and the reduction of adverse consequences of HIV/AIDS on social, labor and economic development. The program is being implemented with support from the U.S. Department of Labor (USDOL). For more details please visit www.ilo.org/hivaidsindia

In 2006, USAID India requested ILO's technical assistance for capacity building and strengthening of workplace programs of USG-supported partners in Tamil Nadu, Maharashtra, Karnataka, and Andhra Pradesh. Since FY07, ILO has been receiving small yearly allocations from the US President's Emergency Plan for AIDS Relief (PEPFAR) to top up the USDOL funding. The PEPFAR contributions obtained so far by ILO have supported the objectives of the USDOL funded program and technical assistance to workplace interventions of USG partners in India in their focus states.

In addition, ILO also mobilized funding from UNAIDS to complement its work on HIV/AIDS in India implemented as part of Joint UN Technical support plan for NACO.

Gender Equality is one of the ten key principles of the ILO Code of Practice on HIV/AIDS and the world of work. It is an integral part of all the workplace policy and program initiatives of ILO HIV/AIDS program. All ILO Sensitization/ Training/ Capacity building program/tools on HIV/AIDS have a Gender component. The Master Trainers/ Peer Educators are sensitized/ trained/ equipped to address the gender dimension in workplace programs and policy. In FY10 the ILO program will continue to address the gender aspects of HIV/AIDS by orienting/ training the tripartite constituents/ partners and stakeholders on HIV/AIDS and gender issues.

ILO proposes to continue with the following technical assistance activities through the USDOL/ PEPFAR FY10 funds, which are part of the strategic framework that ILO has developed for its work in India for 2010-2015 (document attached).

Key Ongoing Activities:

• Strengthen capacity of Ministry of Labour and Employment (MOLE), Employers' and Workers' organizations to implement workplace policy and programs, with focus on informal sector/ migrant workers.

• Strengthen capacity of NACO/SACS to scale up Workplace Interventions (WPI) and Public Private Partnerships (PPPs).

• Offer technical support to large public and private sector companies to develop sustainable workplace policy and programs.

• Strengthen capacity of People Living with HIV (PLHIV) to undertake workplace advocacy and to contribute to reducing stigma and discrimination.

• Provide technical assistance to USG partners for strengthening HIV/AIDS Workplace Interventions in terms of developing a strategic framework; training workplace intervention teams/ partners; review and fine tune existing interventions; share ILO models/ tools/ materials; facilitate partnerships with Department of Labour, employers' and workers' organizations at the state level.

Project Achievements and Innovations:

• Assisted MOLE in developing a National Policy on HIV/AIDS and the world of work; mobilization of resources from Round Nine of GFATM; Mainstreaming HIV/AIDS in MOLE and its institutions: V.V. Giri

National Labour Institute (VVGNLI) that reaches out to approx 3000 participants every year and Central Board for Workers Education (CBWE) that has an annual reach of 300,000 workers almost 70% of whom are unorganized sector workers.

• MOLE is included in the National Council on AIDS and the Country Coordination Mechanism set up for the Global Fund on HIV/TB and Malaria (GFATM).

• Mobilized seven employers' and five central trade unions/ workers' organizations to launch Statement of Commitment on HIV/AIDS. ILO has assisted in development of 397 workplace policies

• Technical Assistance provided to 67 enterprises in five states (2003-2006) reaching 213,422 workers, through 2303 peer educators

• Technical assistance to 12 corporate groups that cover 125,000 workers in 167 locations at their own cost. Under this model, ILO offers technical support and corporate groups develop a workplace policy and program for the entire group, which is implemented by the group at their own cost. This model has facilitated development of Public Private Partnerships (PPP) for prevention, care and support among truckers, migrants/community and supply chain workers.

• Trained 165 PLHIV in workplace advocacy and engaged them at all levels of the program, an achievement that has been appreciated by various evaluations of the ILO program.

• Developed tools for workplace intervention program that have been disseminated nationally and shared with NACO/SACS/USG partners (such as: A manual for Master Trainers/ Peer Educators in the enterprises; A handbook for trade unions, leaflets on HIV/AIDS, Card Game, set of six posters for Workplace program and policy and advocacy film for enterprises and trade unions).

• Developed trade union-led model of working in construction sector. Having built the capacity of unions, ILO has initiated project with most-at-risk workers in the construction sector through trade unions, leveraging funds from UNAIDS.

• Assisted Avert and PSI-Connect projects on workplace programs:
PSI-Connect: ILO provided technical assistance to PSI-Connect in developing a strategic framework for workplace intervention; trained the WPI team of PSI-Connect; provided them with ILO tools for workplace policies and programs (such as posters/ card game etc) that were reprinted by PSI for use in their workplace program; assisted in advocacy with employers' organizations/ chambers and development of enterprise level work on HIV/AIDS; 771 and 130 policies and pledges in Karnataka and Andhra Pradesh

have been developed by PSI to date.

Avert Society: Avert Society was provided technical assistance by ILO in training of workplace coordinator; building capacity of WPI partners of Avert society; shared tools/ material on workplace policy and program; assisted in developing Terms of reference for mapping the organized/ unorganized sector workers and identifying lead agency/ implementing agencies for WPI in Avert identified districts of Maharashtra; shared models of developing workplace policy and program with enterprises/ corporate groups. With ILO's technical assistance AVERT has initiated work with enterprises/ corporate groups as a result, 139 policies have been developed to date.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**10983**		
Mechanism Name:	**Department of Labor**		
Prime Partner Name:	**US Department of Labor**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	OHSS	294,667	

Narrative:

CONTINUING ACTIVITY - NEW ACTIVITY NARRATIVE

SUMMARY

The ILO has developed a three-phase program in India aimed at establishing sustainable national action on HIV/AIDS prevention, care and support in the world of work. With funding from the United States Department of Labor (USDOL), the program started in June 2001 working with government, employers' and workers' organizations, the National AIDS Control Organization (NACO), Employers' and Workers' Organizations (trade unions), UNAIDS, and People Living with HIV (PLHIV). ILO has developed a

Strategic framework for its action on HIV/AIDS in the next five years (2010-2015). The Strategic framework builds upon the work done so far and attempts to contribute towards the overall goal of the National AIDS Control Program - to halt and reverse the epidemic in India.
Highlights of the ILO HIV/AIDS program activities:

The ILO Code of Practice on HIV/AIDS and the World of Work endorsed by the National AIDS Control Organization (NACO) was developed, which includes the national policy on HIV/AIDS and the work developed by the Ministry of Labour and Employment (MOL&E). An 'Indian Employers' Statement of Commitment on HIV/AIDS', signed by seven employers' organizations and a Joint statement signed by the five central trade unions, has been launched. The Indian Network of People Living with HIV/AIDS has endorsed the ILO Code of Practice on HIV/AIDS and the World of Work as a key tool for reducing stigma and discrimination and protecting the rights of PLHIV at workplaces. ILO has assisted the MOLE institutions to integrate HIV/AIDS in their activities.

The ILO HIV/AIDS program contributed to the consultations on the third phase of the National AIDS Control Program (NACP III). As a result WPI has been included in the NACP-III (2007-2012), with recognition of the role of ILO for technical assistance and its constituents. ILO assisted NACO in developing guidelines for strengthening workplace HIV/AIDS programs. These were issued to the State AIDS Control Societies across the country in April 2006.

The ILO HIV/AIDS workplace program materials and lessons have been shared with NACO and other partners. ILO is now engaged with NACO/MOLE in building capacity of State AIDS Control Societies and Technical Support Units on Workplace Interventions. The ILO has developed an advocacy and training package for HIV/AIDS for employers' and workers' organizations. Advocacy meetings and Training of Trainer programs have been organized with employers' organizations at the national and state levels. ILO has also supported pilot projects of unions to cover workers in the informal economy.

ILO has provided training to PLHIV in workplace advocacy and also facilitated setting up of networks of PLHIV in Madhya Pradesh and Jharkhand. In addition, a Handbook for PLHIV on Workplace Advocacy has been developed and printed.

Technical Assistance provided to 67 enterprises in five states (2003-2006) reaching 213,422 workers and 12 corporate groups that cover 125,000 workers in 167 locations at their own cost. This model has resulted in developing Public Private Partnerships in prevention, care and support. ILO has assisted in development of 397 Workplace policies.

ILO proposes to continue with the following technical assistance activities through the USDOL/ PEPFAR

FY10 funds, which are part of strategic framework that ILO has developed for its work in India for 2010-2015.

ACTIVITIES AND EXPECTED RESULTS:

ACTIVITY 1:
Strengthen capacity of Ministry of Labour, Employers' and Workers' organizations to implement workplace policy and programs, with a particular focus on informal sector / migrant workers:
MOLE chairs the Project Management Team of the ILO Project, and leads the tripartite response to HIV/AIDS in the world of work in India. In FY2010-11, ILO will continue to support the MOL&E to set in place sustainable mechanisms for leading the HIV/AIDS response in the world of work and offer the following technical support to the MOLE, employers and workers' organizations:

? Assist MOLE in dissemination of the National policy on HIV/AIDS in world of work: Organize a national level workshop to disseminate the National Policy and train at least 50 labor inspectors in HIV/AIDS- to highlight their role in implementation of the National Policy.
? Assist the MOLE in setting up/ holding meeting(s) of the National Steering Committee on HIV/AIDS and the World of Work (with representatives from tripartite constituents, NACO, ILO, UNAIDS, and INP+) to guide and review the HIV/AIDS policy and programs in the word of work.
? Assist in mainstreaming HIV/AIDS in MOLE and its institutions: V.V Giri National Labour Institute (VVGNLI), Central Board for Workers Education (CBWE), Employees State Insurance Corporation (ESIC), through training and technical support.
? Strengthen capacity of at least five Employers' organizations/ Chambers and five workers organizations to respond to HIV/AIDS. 50 trainers will be trained in these organizations and will be provided ILO tools/ materials for advocacy and training.

ACTIVITY 2:

Strengthen capacity of NACO/SACS to scale up Workplace Interventions (WPIs) and Public Private Partnerships (PPPs):
Workplace interventions appear under the IEC/ mainstreaming component of the NACP-III. Another key component of the NACP-III is PPP. ILO, as the lead UN agency for workplace interventions and private sector mobilization, has helped NACO in drafting guidelines for workplace programs and initiated capacity building of mainstreaming consultants of SACS for WPI/PPP. Continued support from the ILO is expected to effectively integrate and upscale WPI/PPP in NACP-III. This will be offered in the following ways during FY2010-11:
? Organize skills-building workshop for SACS/TSUs on WPI/PPP for participants from at least 20 states,

including the USG focus states.
? Organize a national workshop to share good practices / models in WPI/PPP.
? Facilitate partnership of SACS with enterprises, trade unions and employers' organizations to upscale WPI/PPP.
? Offer technical assistance to NACO/SACS in developing and replicating models of public private partnerships in NACP-III.
? Share ILO tools/experiences/models with SACS for scaling up.
? Assist NACO/SACS in development of advocacy tools/materials for WPI/PPP.

ACTIVITY 3:
Offer technical support to large public and private sector companies to develop sustainable workplace policy and programs:

Public Sector Companies: About 20 million employees are working in Public Sector in India, ILO in collaboration with MOLE is attempting to mobilize Public Sector Enterprises for developing workplace policy and program. This approach will continue and will be expanded.

• Advocacy with central public sector enterprises for HIV workplace policy and program in collaboration with MOLE.
• Provide Technical assistance to at least 10 large Central Public Sector Enterprises (CPSE) for developing a comprehensive workplace program, reaching approximately 1 million employees. 50 trainers to be trained in CPSEs.
• Facilitate partnership with NACO/SACS for setting up counseling and testing centers, Anti Retroviral treatment centers in enterprises engaging their medical/occupational safety and health departments.

Private Sector: ILO has developed and successfully implemented a model of scaling up enterprise-based interventions by partnering with 12 large corporate houses in India. Under this model, ILO offers technical support, and corporate groups develop workplace policies and programs for the entire group, which is implemented by them at their own cost. The corporate groups cover their employees/families as well as their contractual workers, associates, partners and workers in the supply chains. This has resulted in development of PPP for prevention, care and support. This approach will continue to be scaled up during FY2010-11 as follows:
• Scale up the corporate group approach of the ILO. Continue support to the 12 corporate groups; 50 trainers to be trained. Develop collaboration with two new corporate groups.
? Facilitate partnership of corporate groups with SACS for enhancing access to services like condoms, testing and treatment.
? Facilitate partnership of corporate groups with PLHIV networks for advocacy at workplaces to address

stigma and discrimination.
? Assist corporate groups to develop models of public private partnership for HIV/AIDS policy and program, leveraging funds from the MOLE-GFATM Round Nine grant (if it comes through)

During FY10, ILO will continue to offer technical support to public and private sector enterprises and undertake the following:

? Enroll two new Central Public Sector Enterprises (CPSE) and two new corporate groups for developing and implementing workplace policies and programs.
? Train at least 100 trainers on HIV/AIDS in large public and private sector companies.

ACTIVITY 4:

Strengthen capacity of People Living with HIV (PLHIV) for workplace advocacy:
ILO has trained PLHIV in workplace advocacy. Engagement of PLHIV has been a very successful strategy for fighting stigma and discrimination, as noted by all evaluations of the ILO program. PLHIV networks have valued capacity building support from ILO. During FY10 ILO will undertake the following:

? Continue to build capacity of PLHIV networks for advocacy at workplaces and train at least 50 PLHIV in workplace advocacy
? Share copies of the ILO handbook/training film/posters on workplace advocacy by PLHIV, with INP+ and state level networks.
? Continue to facilitate partnership of PLHIV in WPI/PPP programs.

ACTIVITY 5:

Technical Assistance to USG partners for strengthening Workplace Interventions:
ILO will continue to provide Technical Assistance to the USAID India partners in the state of Maharashtra, Karnataka and Andhra Pradesh for strengthening their workplace intervention program.

Till FY08, ILO provided technical assistance to PSI-Connect in developing a strategic framework for workplace intervention; trained the WPI team of PSI-Connect; provided them with ILO tools for workplace policies and programs (such as posters/ card game etc) that were reprinted by PSI for use in their workplace program; assisted in advocacy with employers' organizations/ chambers and development of enterprise level work on HIV/AIDS; In FY09 ILO will provide technical assistance to PSI-Connect for strengthening the capacity of State Department of Labour, sectoral trade unions, employers' organizations/ chambers/ associations and review of workplace intervention/ PPP models.

Till FY08, Avert Society was provided technical assistance by ILO in training of workplace coordinator; building capacity of WPI partners of Avert society; shared tools/ material on workplace policy and program; assisted in developing Terms of reference for mapping the organized/ unorganized sector workers and identifying lead agency/ implementing agencies for WPI in Avert identified districts of Maharashtra; shared models of developing workplace policy and program with enterprises/ corporate groups.
In FY09 ILO will provide technical assistance in developing TOR for mapping of industrial clusters in organized and unorganized sectors in five districts (Avert has identified some agencies who can do this with limited funding within a period of three-four months); short listing sectors (such as construction/sugarcane) with sites for initiating action, companies, clusters of small and medium sector industries etc. Technical Assistance in evaluation of the current WPI of Avert; developing a strategic framework for Avert's WPI, based on the mapping and evaluation. Orientation and training of the new workplace Coordinator and Partner agencies; Advocacy with management of current/potential partners for WPI; Development of state - sector specific IEC material;

Building on the work done under COP 2009, the ILO proposes following activities under COP 2010:
For Avert Society: ILO will offer technical assistance for developing/ implementing workplace intervention models in selected sectors/ districts (such as construction, sugarcane) and capacity building of Avert society/partners, as per the strategy proposed to be developed in 2009-10 in collaboration with Avert-ILO. Specific Technical assistance plans from ILO will depend on the strategy and will be discussed and finalized in consultation with Avert.

For PSI Connect project: ILO will continue to provide Technical Assistance to PSI in the activities agreed for 2009-10; Since FY10 is likely to be the last year of PSI-Connect, the focus will be on Evaluation and Dissemination of models/ tools. ILO will provide technical assistance in Documentation of models of WPI/ PPP that have scope for replication at national level and Joint Dissemination of WPI models.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12401	**Mechanism Name: Family Health International**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement

Prime Partner Name: Family Health International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 600,000	
Funding Source	**Funding Amount**
GHCS (State)	600,000

Sub Partner Name(s)

TBD		

Overview Narrative

Under the newly initiated (September 2009) "Technical Assistance to the National AIDS Control Organization (NACO) for HIV/AIDS Surveillance" Project funded by Centers for Disease Control (CDC), Family Health International (FHI) will provide technical assistance (TA) at the national, state and district levels in specific strategic information (SI) areas. The Project will ensure synergized TA efforts with other USG and non-USG partners and will not duplicate existing SI resources and efforts.

The core areas of TA on SI as envisaged over the medium and long-term include: 1) Monitoring and Evaluation (M&E) of CDC-funded projects; 2) Surveillance TA including developing quality assurance (QA) for existing surveillance systems; and 3) Data Use TA including analysis, epidemiological modeling, estimation and projection; and data reviews.

The geographical focus of the project activities will be National and select CDC states.

Key collaborating partners under this Project include: NACO; USAID; WHO; UNAIDS; National Institute of Medical Statistics (NIMS); National Institute of Health and Family Welfare (NIHFW); the Indian Statistical Institute (ISI); and the six Regional Surveillance Centers (Post Graduate Institute of Medical Education and Research (PGIMER), National Institute of Epidemiology (NIE), All India Institute of Medical Sciences (AIIMS), National AIDS Research Institute (NARI), National Institute for Cholera and Enteric Diseases (NIECD) and the Regional Institute for Medical Sciences (RIMS).

In FY10 (October 2009-September 2010), the key focus of the Project was on completion of preparatory activities to support the roll-out of TA in the above areas. The key activities included: staffing and drawing-on global and in-country resources; meeting with key stakeholders at the national and state level for

consensus building and clear delineation of TA areas to avoid non-duplication; protocol/manual review, adaptation and development (as necessary); and seeking necessary approvals and compliances from NACO and CDC.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	80,000

Key Issues

Impact/End-of-Program Evaluation

Budget Code Information

Mechanism ID:	**12401**		
Mechanism Name:	**Family Health International**		
Prime Partner Name:	**Family Health International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	HVSI	600,000	

Narrative:

SUMMARY
In FY11, FHI will provide TA on SI in the following three prioritized categories: 1) Monitoring and Evaluation (M&E) of CDC-funded projects; 2) Surveillance including developing quality assurance (QA) on existing surveillance systems; 3) Data Use including analysis; modeling, estimation and projections; triangulation and data reviews.

STAFFING AND MANAGEMENT
FHI will build-on the preparatory work undertaken in Year 1 of the grant. The staffing will be revisited based on the detailed TA areas identified in consultation with key stakeholders including NACO, WHO, USAID and CDC. Besides the full-time Principal Investigator and senior SI Specialist recruited on this Project in FY10, an additional full-time Surveillance Specialist will be hired in quarter 1 of FY11. The FHI India Country Office support units including the Country Director, Director, Shared Services and Director, Programs will continue to provide oversight and support to the Project. FHI will also continue to draw on

its pool of in-country and international experts as well as resources and tools for TA provision in the defined areas.

COORDINATION WITH STAKEHOLDERS
Efforts undertaken in FY10 to build consensus and ensure non-duplication of TA in SI areas would result in a clear delineation of TA at the national, state and district levels. Active dialogue, consultations and discussions will continue to be held with key stakeholders including: Technical Resource Groups on Surveillance and M&E at NACO, UNAIDS Modeling Projection Group, WHO, and the national institutes especially NIMS, NIE and NIHFW. Based on the results of the mid-term review (MTR) of NACP III, new areas of TA may be identified for which FHI will engage in a dialogue with NACO, other USG and non-USG partners. For the evaluation of CDC-funded projects in India, the Evaluation Core Group (ECG) constituted by FHI in FY10 will meet at least twice in FY11 for the following: sharing of key evaluation findings and recommendations and working-out a dissemination plan.

In FY11 the following activities will be undertaken:

ACTIVITY 1: Monitoring and Evaluation (M&E) of CDC-funded projects:
Guided by the CDC approved evaluation protocols, FHI will undertake end-line evaluations of pre-defined CDC-funded projects in India. As indicated by CDC, these will include: Public Health Nurses Project in communities implemented by Christian Health Association of India (CHAI); AP-AIDSCON project with universities; and a HIV Care, Support and Treatment project implemented by Myrada. Evaluation teams will be constituted for each of the projects and timelines for the evaluations will be worked-out in consultation with CDC and the implementing agencies. Once evaluation results are documented, FHI in consultation with CDC will decide on appropriate dissemination channels that may include publications and dissemination meetings to be held in FY11 and FY12.

ACTIVITY 2: Surveillance TA
Sentinel Surveillance: FHI as a member of the National Technical Working Group on Surveillance will provide TA to strengthen second generation surveillance activities; including strengthening QA systems of the six Regional Surveillance Centers and monitoring the quality of surveillance activities such as site selection, sample collection, sampling, data management and analysis. A key contribution will be towards strengthening sentinel surveillance of high-risk-groups (HRGs). FHI will share tools, guidelines and conduct trainings for the six Regional Surveillance Centers on QA for improved surveillance systems at the state and district levels.

Behavioural Surveillance: At the national level, the protocol for IBBA (-lite) has been developed. Building on FHI's current experience in providing TA on the IBBA, FHI in collaboration with WHO and UNAIDS,

will provide TA to NACO to design and implement IBBA (-lite) in select districts/epidemiological zones of the country. This will be contingent on NACO plans. FHI along with the National AIDS Research Institute (NARI), the implementing partner for the FHI-led IBBA, will fine-tune the protocol, provide the tools and operational guidelines for undertaking IBBA (-lite) in select sites.

Mapping: In collaboration with WHO and UNAIDS, FHI will initiate a comparative analysis of different mapping methodologies applicable for HRGs and bridge populations in HIV high prevalence and vulnerable states.

ACTIVITY 3: TA on data use

TA on Integrated Analysis: Integrated analysis is being currently undertaken for the 'A' and 'B' category districts in all the high prevalence states (except Nagaland) and West Bengal, Uttar Pradesh and Gujarat. Through this Project, FHI proposes to undertake integrated analysis of available HIV data in the 'C' and 'D' category districts, many of which are considered 'vulnerable' districts by NACO. Information garnered from the analysis will be used to inform the national program and provide data for better policy and programming in these districts.

TA on Estimation of PLHIV: FHI will provide TA to two priority CDC states on arriving at state estimates of HIV cases using latest epidemiological models, including the Asian Epidemic Model (AEM), that will support revision/updating of the NACP projections and assumptions for both HRGs and People Living with HIV (PLHIV). This will be done through the setting-up of state-level working groups that will include the relevant Regional Surveillance Centers; State AIDS Control Societies (SACS), and other state level stakeholders.

Size Estimation for HRGs: Building on the size estimation undertaken during Round 1 of the IBBA, FHI will provide TA on different size estimation methodologies (Multiplier, Capture-Recapture) to the Regional Surveillance Centers to undertake size estimation for HRGs in at least two states. To enable states to eventually lead the process, guided by the results of the training and TA needs assessment, FHI will undertake a series of capacity building interventions with the relevant staff of NIMS, NIHFW, State Training and Resource Centres (STRCs), Technical Support Units (TSU) and the Regional Surveillance Centers. This will include a mix of sharing technical resources and tools, on-site mentorship through deputing experts on surveillance, and structured trainings and workshops organized in consultation with NACO/SACS.

Data Review: In order to improve the quality of HIV data being collected at different levels and through different sources, FHI in partnership with NACO, SACS and the National Institutes will initiate a comprehensive data review which will entail listing of different data sources, analysis of different methods

and system of data collection; and review of data quality to recommend steps on how the system of data collection and quality can be improved. This exercise will be initiated in the CDC-priority states. TA on Modeling: FHI in collaboration with WHO, NIHFW and NIMS will undertake trainings in modeling (using existing modules) for staff from SACS, state level institutions and NIE. Once trained, FHI will provide TA on use of different models at the state-level in the CDC-priority states. Indicator targets: The activities under this budget code area will be monitored by the following output level indicators: • Number of local organizations provided with technical assistance for strategic information activities; and • Number of individuals trained in SI (includes M&E, surveillance, and/or HMIS) In FY11, a total of 20 organizations and 100 individuals will be reached under this budget code area.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12402	**Mechanism Name: Project Concern International**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Project Concern International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 700,000	
Funding Source	**Funding Amount**
GHCS (State)	700,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Laboratory systems and practices in India in the context of Public Health and Public Health programs

have been less prioritized historically and the role has been largely limited to providing periodic, need-based assistance to programs as well as primary and secondary health facilities, rather than providing ongoing technical assistance (TA) and leadership. Though over the last two decades, India has invested in establishing more than 5,000 HIV/Opportunistic Infection (OI) diagnostic facilities including integrated counseling and testing centers (ICTCs), CD4 and ART centers and Community Care Centers (CCCs). However, the laboratory services at these centers range from non-existent to functional with minimal or no quality assurance.

In the National AIDS Control Program third phase (NACP-III), the Government of India (GOI) aims to establish quality laboratory diagnostic systems providing ongoing quality assurance to peripheral institutions, strengthening the lab data management systems and emphasizing the establishment of minimum quality standards in the public and the private health care delivery system. In this regard, NACP-III has designated 1 Apex laboratory, 12 National Reference Laboratories (NRLs) and117 State Reference Laboratories (SRLs) to strengthen the laboratories at the service delivery points.

To expand and strengthen TA and collaboration at national, state and district levels to more effectively design, implement, and monitor HIV/AIDS programs through the strengthening of government-initiated laboratory systems in India, CDC has signed a new Cooperative Agreement (Co-Ag) with Project Concern International (PCI). Through this Co-Ag, PCI will initiate a project named PRATIBHA (Project for Accelerated Technical Assistance and Integrated Capacity Building for HIV/AIDS). The overall purpose of PRATIBHA is to strengthen laboratory services in India by focusing on the NACP-III priorities designed to increase effectiveness, efficiency and accountability with regards to HIV testing. The objectives of the project are to provide:

1. Training to improve skills and knowledge of laboratory workers and the upgrading of public and private laboratories at all levels
2. Implementation of quality assurance mechanisms at all NRLs, select SRLs and ICTCs
3. Strengthening of supervisory mechanisms to ensure laboratory adherence to quality standards, such as proficiency testing and a nationwide accreditation system
4. Recommendations for implementation of cutting-edge specimen collection technologies for HIV testing

Project PRATIBHA's proposed set of activities draws significantly from findings and the recommendations from the NRL assessment exercise, facilitated by PCI for all NRLs conducted in year 2008 by the CDC in collaboration with WHO and NACO. The exercise highlighted challenges related to various issues such as technical, operational, human resource, capacity building and equipment. Based on the findings related to the direction and strategic vision for laboratory systems strengthening reflected through the NRL assessment, PCI proposes to undertake eight main activities for all 13 NRLs, 40 SRLs (all across India) and 20 ICTCs (10 each in Andhra Pradesh and Tamil Nadu) for the period starting from September 30,

2009 till September 29, 2010. These activities are:
1. Human capacity development of laboratory program managers and staff
a. At NRL level
b. At SRL level
c. At SACS level (Blood safety and Laboratory team/s)
2. Technical assistance in developing qualitative standardized manuals, standard operating procedures (SOPs) and documentation at the NRL and SRL levels.
3. Regional consultancy and technical assistance through placement of consultants as lab advisors-cum-coordinators for strengthening the NRLs primarily and SRLs and acting as a bridge between laboratories.
4. South-to-South collaborations for exchange of lab- related experience and expertise by senior level laboratory persons at NACO and NRLs.
5. Setting up model NRLs and SRLs
6. Follow-up of NRLs assessments as a field review of action taken
7. Follow-up of SRLs assessments as a field review of action taken
8. Training of laboratory personnel in Laboratory Management Information Systems (LMIS)

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Workplace Programs

Budget Code Information

Mechanism ID:	**12402**		
Mechanism Name:	**Project Concern International**		
Prime Partner Name:	**Project Concern International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	OHSS	300,000	
Narrative:			
Background			

CDC has singed a new Cooperative Agreement (Co-Ag) with Project Concern International (PCI). Through this Co-Ag, PCI will initiate project named PRATIBHA (Project for Accelerated Technical Assistance and Integrated Capacity Building for HIV/AIDS). The overall purpose of PRATIBHA is to strengthen laboratory services in India by focusing on the NACP-III priorities designed to increase effectiveness, efficiency and accountability with regard to HIV testing

ACTIVITY 1: TECHNICAL ASSISTANCE IN DEVELOPING QUALITY MANUALS, SOPS AND DOCUMENTATION AT THE NRL AND SRL LEVEL.

This activity will include following initiatives:
1. A Prototype Quality Manual preparation: A PCI team composed of the representatives of NRLs, a senior level lab assessor and a program person will be assigned the responsibility of drafting the "A Prototype Quality Manual". This manual will address both management and technical issues and will have clear mention of the quality policy of the laboratory. The draft manual will be peer reviewed by certified assessors and the finalized document will be handed over to NACO for wider dissemination.

2. Supply of NABL Base documents to NRLs: The base documents and templates will be procured from CDC and NACO. In addition, PCI will procure the NABL standard documents (ISO-15189, NABL-112 and NABL-160), and supply copies of these to all NRLs.

3. Drafting of Standard Operating Procedures and Job-aids: In the first year, PCI will initiate work on development of SOPs and Job-aids on various topics such as specimen collection and transportation, and accept /rejection criteria etc. In addition, standardizing recording and reporting forms for common processes will be done. Since the testing kits are often changing, PCI will initiate work towards development of prototype SOP for some well-known and widely used test kits. Additionally, PCI will prepare guidelines on how labs can prepare SOPs in anticipation of a new HIV test kit.

By the year-end, PCI will equip 13 NRLs, 40 SRLs and 20 ICTCs with the select manuals, job-aids and SOPs and will train a total of 216 personnel from 13 NRLs, 40 SRLs, and 20 ICTC on use of these documents.

ACTIVITY 2: REGIONAL CONSULTANCY AND TECHNICAL ASSISTANCE

In year one, consultants will be placed at the regional sites (one at Pune to support the Apex NRL, another at eastern region/ North-eastern states, and third one at Chennai (to support south India labs) for continued support to NRLs/ SRLs. Preferably, PCI will aim at hiring consultants who are NABL trained.

The expected roles of these consultants will be to:

1. Assist PCI Delhi team in writing of the quality manuals/ documentation
2. To conduct regional training for SRLs
3. Ensure implementation of the procedures (on which staff is trained)
4. Help NRLs and SRLs to write QM, and other documents for accreditation/ other proposes
5. Help NRLs and SRLs to assure quality on regular basis
6. Address any other technical issues, emerging with the SRLs or NRLs
7. Conduct internal audits of different NRLs/ SRLs

ACTIVITY 3: SOUTH- TO – SOUTH COLLABORATION

South-to-South partnerships create an effective platform for building sustainable institutional and human-resource capacity through open exchange of knowledge, information, and professional experience. A regional collaboration will add an important dimension into training programs; an international problem oriented perspective, to enable training of specialists in a multidisciplinary fashion with a broader target oriented framework.

PCI will assist the state and national-level public health workforce in sharing experiences at the international level – preferably with other USG partners in the South – focusing on areas of laboratory and health systems strengthening. In this year, PCI will work to explore options of establishing south-to-south faculty and student exchange programs between India and other countries. In addition, PCI will encourage public health experts to experience study tours, meetings, conferences, and other relevant short-term trainings.

ACTIVITY 4: SETTING UP OF MODEL NRLS AND SRLS

PCI's aim is to set up one NRL and one SRL as model laboratories. The model SRL/NRL will have following:

- Standardized recording and reporting forms
- Job Aids in place
- A manual on quality standards
- Customer satisfaction survey
- Proper number of well trained staff
- All equipment in place
- And Accredited to NABL

ACTIVITY 5: FOLLOW UP OF THE NRLS ASSESSMENTS

PCI will procure the NRL assessment report from NACO, and will prepare a baseline document, which will be used to review the progress made on lab strengthening in year 2 and/or later. PCI seeks facilitation from CDC in procurement of the reports from NACO.

ACTIVITY 6: FOLLOW UP OF THE SRLS ASSESSMENTS

PCI will procure the SRL assessment report from NACO, and will prepare a baseline document, which will be used to review the progress made on lab strengthening. PCI seeks facilitation from CDC in procurement of the reports from NACO.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	400,000	

Narrative:

Background

CDC has singed a new Cooperative Agreement (Co-Ag) with Project Concern International (PCI). Through this Co-Ag, PCI will initiate project named PRATIBHA (Project for Accelerated Technical Assistance and Integrated Capacity Building for HIV/AIDS). The overall purpose of PRATIBHA is to strengthen laboratory services in India by focusing on the NACP-III priorities designed to increase effectiveness, efficiency and accountability with regard to HIV testing.

ACTIVITY 1: HUMAN CAPACITY DEVELOPMENT (HCD) OF LABORATORY PROGRAM MANAGERS AND LAB STAFF

This activity would be undertaken at three different levels, namely:
(1) At the NRL level: The HCD initiative will be undertaken for staff from all 13 NRLs. At each NRL, trainings will be provided to the Laboratory-in-Charge, the Medical Officer, the Lab Technician and the Lab Assistant. The HCD initiatives at this level will comprise of a three-day national training program for NRL Labs-in-Charge from all NRLs. An expert group involving NRL team leaders on technical, managerial and quality aspects will conduct this training. In addition, two bench trainings of the technical staff and one training program for medical officers from all NRLs will be held.
(2) At the SRL level: PCI will conduct four regional trainings for 40 selected SRLs. This will include two training programs for SRL Laboratories-in-Charge and two regional training programs for Lab

Technicians and Lab Assistants.
(3) At the SACS level: An assessment of training needs will be conducted for select teams from Andhra Pradesh and Tamil Nadu SACS on the issues of blood safety and laboratory-related procedures. This assessment would identify training needs and capacity gaps that are crucial for quality improvement of the lab services in the state. Secondly, select staff from the 20 ICTCs (10 from AP and 10 from TN) will be trained on the issues mentioned above. This training would be conducted in close collaboration with the CDC partner agencies located in these states, for example PHMI in AP and I-TECH in TN.

By the year's end, through these initiatives on HCD, PCI will train a total of 216 personnel from 13 NRLs, 40 SRLs, and 20 ICTCs. The training topics will include technical information on HIV/AIDS, HIV prevention, blood safety, testing procedures, interpretation of results, reporting and proper disposal of waste, personal safety, post exposure prophylaxis, quality control and quality assurance. The topics will be finalized after consultation with CDC and NACO. For training purposes, PCI will procure training manuals from NACO, adapting its content for relevance and technical updates before implementation.

ACTIVITY 2: TECHNICAL ASSISTANCE IN DEVELOPING QUALITY MANUALS, SOPS AND DOCUMENTATION AT THE NRL AND SRL LEVEL.

This activity will include following initiatives:

1. A Prototype Quality Manual preparation: PCI will convene a team of experts comprising of NRL representatives, a senior level lab assessor and a program person to draft the "A Prototype Quality Manual". This manual will address both management and technical issues and will have clear mention of the quality policy of the laboratory. The draft manual will be peer reviewed by certified assessors and the finalized document will be handed over to NACO for wider dissemination.

2. Supply of National Accreditation Board of Laboratories (NABL) Base Documents to NRLs: The base documents and templates will be procured from CDC and NACO. In addition, PCI will procure the NABL standard documents (ISO-15189, NABL-112 and NABL-160), and supply copies of these to all NRLs.

3. Drafting of Standard Operating Procedures (SOP) and Job-aids: In the first year, PCI will initiate work on development of SOPs and job-aids on various topics such as specimen collection and transportation, and acceptation /rejection criteria, etc. In addition, standardizing recording and reporting forms for common processes will be done. Also, due to confusion over the changing contents of test kits, PCI will initiate work towards the development of prototype SOPs for some well-known and widely used test kits and will prepare guidelines on how labs can prepare SOPs for a new HIV test kit.

By the end of the year, PCI will equip 13 NRLs, 40 SRLs and 20 ICTCs with the select manuals, job-aids and SOPs, and will train a total of 216 personnel from 13 NRLs, 40 SRLs, and 20 ICTC on effective use of these documents.

ACTIVITY 3: REGIONAL CONSULTANCY AND TECHNICAL ASSISTANCE

In year one, consultants will be placed at the regional sites (one at Pune to support the Apex NRL, another at eastern region/North-eastern states, and the third in Chennai to support south India labs) for continued support to NRLs/ SRLs. PCI will aim to hire consultants who are NABL-trained. The expected roles of these consultants will be to:

1. Assist PCI Delhi team in writing of manuals/ documentation
2. Conduct regional training for SRLs
3. Ensure implementation of the procedures (on which staff is trained)
4. Assist in strengthening the capacity of the NRLs and SRLs to write quality manuals, and other documents for accreditation/ other proposes
5. Help NRLs and SRLs to assure quality on regular basis
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7. Conduct internal audits of different NRLs/ SRLs

ACTIVITY 4: SETTING UP OF MODEL NRLs AND SRLs

PCI will establish one NRL and one SRL as model laboratories. The model SRL/NRL will have following:

1. Standardized recording and reporting forms
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5. Proper number of well-trained staff
6. All equipment in place
7. And Accredited to NABL

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ACTIVITY 5: FOLLOW UP OF THE NRL ASSESSMENTS

PCI will procure the NRL assessment report from NACO and prepare a baseline document, which will be used to review the progress made on lab strengthening in year 2 and/or later. PCI will seek facilitation from CDC in procurement of the reports from NACO.

ACTIVITY 6: FOLLOW UP OF THE SRL ASSESSMENTS

PCI will procure the SRL assessment report from NACO and will prepare a baseline document, which will be used to review the progress made on lab strengthening. PCI will seek facilitation from CDC in

procurement of the reports from NACO. ACTIVITY 7: LAB MANAGEMENT INFORMATION SYSTEMS (LMIS) PCI will work to strengthen labs on data access security, data transfer integrity, management of incoming and outgoing information, systems for creating and archiving documentation and compliance with international guidelines. For this, PCI will undertake following activities: 1. Information technology needs assessments for select NRLs and SRLs 2. Development of LMIS and its implementation in select NRLs and SRLs on pilot basis 3. Development of LMIS manual and training of the lab staff on use of LMIS PCI will hire an expert to undertake the above mentioned activities. This expert will be drawn from the list of experts mentioned in the proposal.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12403	**Mechanism Name: TBD**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

National AIDS Control Organization (NACO) has identified priority thrust areas under its 3rd phase of

National AIDS Control Program (NACP – III) that includes providing high quality care, treatment and ART services within the national framework to PLHIVs that are accessible, appropriate and affordable.
Some of the major challenges faced in providing above services as the program has evolved during the program include rapid scale up of service delivery across the country, quality issues, limited skills and knowledge among practicing health-care providers, both in the public as well as the private sector. Besides, robust systems for clinical care and service delivery are lacking due to staff vacancies, supplies issues, quality issues etc.
USG will work with local government counterparts both at the State and National level and other NGO partners in fostering partnerships within the public and private sector for HIV diagnosis, clinical care services, capacity building of the healthcare staff (medical, paramedical and allied staff), private sector policies, public private partnership models, laboratory systems and innovative partnerships models.
This project will have the following key approaches:
a) Work collaboratively with the Government counterparts in providing TA in designing, planning and implementing HIV clinical care and ART service models.
b) Develop and innovate partnerships within the Public sector and PPP to strengthen and scale up HIV services delivery
c) Enhance clinical capacities among the hospital workforce for quality services delivery thro competent workforce
d) Provide high quality TA at the National and State level in establishing Centers of Excellence as tertiary centers of HIV services delivery, trainings and research.
e) Develop a unique ART program mentoring & human capacity development program
f) Systems and policy strengthening by providing consultancy, manpower and Technical assistance on a need basis at District, State and National level for Clinical services.

ACTIVITY I: Technical Support District level network (partner TBD) for institutional capacity building

In spite of several donors funding the various positive networks for programs, there has not been much emphasis on building the governance, institutional capacity financial management and vision building of these networks to cope with their program management.

Through a TBD (developmental partner), USG will focus on building institutional capacity of PLHA organizations affiliated to INP+ along with strengthening management, monitoring and evaluation and reporting systems. The activity will be within the states of Tamil Nadu, Karnataka and Andhra Pradesh.

It will explore the possibility of forming cluster level PLHA groups, who in turn will be represented in the DLN core group. This model is based on MYRADA's successful model of linking women SHGs with a community managed resource centre (CMRC). This CMRC is represented by SHG members and

responds to their needs to provide services directly and arrange linkages. The model will include forming and strengthening PLHA groups at cluster level (Gram Panchayat or PHC level). The formed groups will then work with the DLN to ensure that they are adequately represented in the DLN governing structure. This model is going to be implemented in 2 districts of Karnataka in close partnership with the Karnataka Network of Positives (KNP+). In FY2010 and FY 2011, TBD (Developmental partner) and INP + will consolidate the learning from this model and determine if it can be replicated in other districts.

TBD (Developmental Partner) will also focus on strategies to strengthen the services managed by DLNs so that they function as effective community managed resource centers for their member PLHAs. Special training programs will be held for the staff of the district positive networks on palliative care programming, and how to plan and manage such a program in their network area. Included in the package will be trainings on positive prevention counseling using the USG-developed toolkit.

ACTIVITY II: Technical Support to Link Worker Program

? Link Worker Scheme - In order to reach rural Female Sex Workers (FSWs) and other high risk population in the rural areas and people living with HIV (PLHIVs) within the high HIV prevalence districts (A and B as per NACO guidelines), Link Worker Program is being implemented in the field through NGOs in the identified high risk villages in districts. The following are some important activities conducted through the program
? Core group interventions for high risk groups – condoms, STI and awareness – through Community Resource Persons (CRPs) and local volunteers.
? Program for adult men in informal groups and women in SHGs – which includes basics of HIV and STIs for the adults, addressing stigma and discrimination, and roles of these populations in HIV prevention and care, and stigma reduction
? Youth interventions using the Celebrating Life curriculum to address life skills and role of youth in mitigating stigma and discrimination.
? Strengthening the community based institutions – Gram Panchayat (GP) or the village council and Village Health and Sanitation committees (VHSC).
? Gram Panchayat sensitization programs in high risk villages
? Capacity building of VHSCs in collaboration with NRHM program
? Community based care and support for PLHAs and OVCs
? Counseling and Testing through Mobile Teams at select remote PHCs

The Link Worker program activities cuts across several program areas including PMTCT, TB/HIV, abstinence and being faithful, other sexual prevention, adult care and support and health system strengthening. It covers the adult men, women, youth, pregnant women, high risk groups, PLHIVs and

OVCs in the village, as well as the VHSCs and Gram Panchayats. The other program areas also highlight specific activities being carried out through the Link Worker program.

MYRADA had developed a detailed strategy document to explain its processes in the Link Worker Program since the NACO operational guidelines did not have the "how" to implement details. This program is being implemented in 3 phases:

a. an initial 2 year phase of preparing the community and service delivery points;
b. a one year consolidation phase of strengthening the local structures in the community
c. a one year handing over and withdrawal phase

In order to ensure that the program does get integrated with the government-run general health delivery and social development system in the field, it is important to continue this activity in some districts and provide high quality intensive Technical Assistance to NGOs working in other high prevalent districts across the country.

Through a TBD (developmental partner), the following field level activities will be carried out in the demonstration sites

• Working with High-Risk Groups: These high risk groups comprise female sex workers, men who have sex with men, IDUs and regular clients of sex workers. There is a focus to provide one to one outreach with these groups. The Link worker ensures that all those self identified receive information on HIV and related issues to reduce the risk, get an adequate supply of condoms (directly or through condom depots), and have a medical check-up regularly to rule out STIs. All sex workers are referred for voluntary counseling and testing (VCT). This has already been initiated in all the districts and will continue in this year.

• Working with adult men, women and youth: This includes specific trainings for women in Self Help Groups (SHGs), adult men and youth in the villages. These trainings were to enable them to understand the dynamics of HIV transmission and prevention, as well as to get them to address issues related to stigma and discrimination.

• Strengthening the Village Community Structures and Local Governance Units: It is important to strengthening the community institutions – the Gram Panchayat and the VHSC. VHSC is group of representative members from women's groups, Gram Panchayat, and the local health department are selected by the general community to take up certain responsibilities in the village including: organizing regular awareness programs, setting up and maintaining condom outlets, addressing HIV facilitating co-factors such as alcohol abuse, and providing support and linkages to Most At Risk Populations and PLHAs. All Gram Panchayats and VHSCs in the high risk villages in the high HIV prevalence districts will undergo a standardized training and then have regular monthly meetings. This activity will be linked with

advocating for policies on the formation of these sub committees with the Rural Development and Panchayat Raj Ministry.

• Capacity Building of Outreach Staff Working with Most at Risk Populations: This is important to ensure all Link Workers and supervisors are equipped with knowledge and skills to address all high risk groups in the villages.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12403**		
Mechanism Name:	**TBD**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	Redacted	Redacted

Narrative:

Summary

The Government of India had in 2007 revised the National estimates for prevalence of HIV/AIDS. At 0.33 percent among the adult population the estimated adult population living with HIV/AIDS is estimated to be about 2.5 million.

National AIDS Control Organization (NACO) has identified priority thrust areas under its 3rd phase of National AIDS Control Program (NACP – III) that include, MARPs saturation, rapid scale up of services, improved program management systems, decentralization of program implementation and management to the district level, strengthened data, strategic information management systems and with a focus on access to quality services, mainstreaming of HIV services to other Health and non-health departments and integration with the existing General Health care delivery services.

One of the major challenges faced during the evolution of the program has been the limited skills and knowledge among practicing health-care providers, both in the public as well as the private sector.

Besides, robust systems for clinical care and service delivery are lacking due to staff vacancies, supplies issues, quality issues etc.

To add to the challenges in the health care services delivery, in India, significant level of health services (60%) are sought in the Private sector that has remained untapped and unmonitored, with HIV/AIDS care and ART treatment services too being constrained by insufficient access to entry points, low treatment literacy among health workers and the general population, stigma and discrimination among the providers being high as well as non-uniformity of services and non-conformity to the national strategies, lax or lack of systematic reporting systems in the private sector data generation and lastly challenging compilation and reporting.

To address the above USG PEPFAR lists to implement following activities in the priority States and at the National level.

Activity 1: Technical Assistance and Support to Centers of Excellence at the National level

The agency to partner with State and National government counterparts to provide technical support in the form of direct skilled manpower who are placed as Technical Consultants at the Centre of Excellence (COE) or an organization to organization TA. Based on program priorities and COE needs this support will be in critical areas of Care and Treatment services delivery, trainings and TA for operational research within the COE. This will aim to improve and strengthen the systems within the CoE for high quality program implementation, monitoring and review of the care, Support and Treatment components in line with the national guidelines under NACP III. The broader goal of this will be to establish sustainable systems with adherence to national guidelines and build in-house capacities of the Govt. and Program staff through mentoring, on-the-job training assistance and supportive supervision.

Some key areas that will be focused on:

a. Logistics and Supply Chain & Systems management including Patients flow management; Supplies, Logistics & Inventory; Staffing / HR & performance / turn-over issues; Coordination /Liaising aspects between various hospital departments housing ART centers with Laboratory and other clinical departments and administrative wings.

b. TA for clinical aspects including quality of HIV care which includes both first line and Second line ART, adherence issues, switch of regimen, TB-HIV; infection control, lab upgrades, infection control and waste management, QA issues in diagnosis, treatment and care.

c. Facilitating staff capacity development thro Trainings for the various cadres of health care providers including Medical Graduates, Interns and Post Graduates.

d. Initiate other academic programs around the CoE for HIV/AIDS such as: Fortnightly journal clubs; Monthly CMEs; Monthly Grand ID rounds; periodic thematic integrated teaching sessions; periodic Guest lectures etc

e. TA for Operational Research

f. Provide TA in setting-up an HIV hotline for PLHIV support.

g. Will coordinate with the COE to initiate the State and / or National level HIV conference once in two

years with multi-partner support, funding & NGOs
h. Will give TA to establish Virtual Resource Library utilizing the funds of COE
i. Will provide TA support to establish a Strategic Information Management Unit - basically a data management systems support at CoE level
Activity 2: Technical support to States and NACO for strengthening and providing high quality HIV care, treatment and ART services within the National program
Direct TA through consultants as technical experts, as well as organization to organization support at State and National level to build local internal organization staff capacities in planning, execution, reviewing and monitoring of Care, Support, Treatment and ART services delivery.
Specific activities within this support include: 1) building interest in evidence-based program planning with a primary focus on the Treatment outcomes which will include both first line and Second line ART; 2) Review the data from the ART, Community Care Centers and Link ART with APSACS staff, relevant NGOs, and district staff for timely program modification and decision making; 3) integrating the data from the CCC, ART and the Link ART centers for a definitive outcomes from the ART program implementation; 4) Take lead in coordinating the activities in The COE as per the National Guidelines of COE; 5) Evaluate the functioning of the CCCs ,ART centers and Link ART centers in the State along with the Care Support and Treatment team of SACS and; 6) Disseminating critical operational issues based on the evidence from the field to opinion leaders and program managers.
Activity 3: Technical support for enhancing clinical capacity for HIV care and treatment services providers e.g. Doctors, Nurses both in the Public and Private sector
In India HIV/AIDS care and treatment services continue to be constrained by insufficient access to counseling and testing services, due to the low treatment literacy among health workers and the general population, stigma and discrimination among the providers being high as well as in Private sector, non-uniformity of services and non-conformity to the national strategies, lax or lack of systematic reporting systems in the private sector data generation and lastly challenging compilation and reporting.
To bridge the HIV skills and knowledge gap among practicing health-care providers both in the Public as well as Private sector, in-service HIV training courses will be undertaken as an immediate response to an acute need for rapid HIV prevention, care, and treatment scale-up, training needs have evolved over time. Training programs with innovative, feasible and acceptable methodologies need to be built to provide sta? with regular updates on HIV knowledge into in resource-limited settings.
Activity 4: Integration of Private sector HIV services delivery models into the National program including those for diagnosis, care, treatment and ART
To establish and strengthen a meaningful role for private sector involvement in HIV/AIDS services delivery more effectively to address the issues and needs at the State as well as National level particularly relating to Care ,Support and Treatment. The purpose is to work in tandem with the local host Government State AIDS Control Society (SACS) and NACO to expand HIV/AIDS program interventions in the Private sector systematically and in an all inclusive manner bring the private sector into the fold of

the public sector for delivering standardized HIV services as per the National guidelines.
This activity will also specifically facilitate networking of engaged and interested Private sector institutions to conduct training programs at the district level for physicians and nurses to manage PLHIVs in the private sector without stigma, Discrimination or Denial.
Activity 5: Establish ART centers under the partnership model
Concerted evidence based efforts to creatively advocate for and establish ART centers in the Private medical institutions as per the national protocols with funding support from the Government leveraging the existing resources from the Private sector, particularly to reach to the significant number of PLHIVs who seek services within the Private Sector and decongest the ART centers in public sector in order to enhance the quality of clinical services.
Activity 6: Establish and Operationalize of Link ART centers (LACs)
Will provide technical Assistance to the staff of LACs in terms of onsite mentorship and one to one interactions to tide over potential technical as well as operational barriers for implementation of quality program. The centers will be established in the existing Health system utilizing the services of existing human Resources the main obstacle would be lack of technical capacity of the staff in managing PLHIVs including OI and ART, Stigma and Discrimination, Documentation and data Management and weak supportive Supervision systems due to rapid scale up. On site mentoring would be the key strategy to establish LACs with TA addressing the above issues.
Activity 7: ART Training fellowship for in-service ART Medical Officers in the National program
There is an urgent need for trained quality ART clinical service providers, with the rapid expansion of ART centers undertaken by National AIDS control organization. To improve the quality of services in these ART centre, there is a requirement of a long term in-service training and mentoring. Long term training and follow up of ART Medical Officers is envisaged through a clinical fellowship planned as an on-the-job training for the ART Medical Officers who will come for regular contact sessions which will include theory lecture as well as intense bed side clinical teaching and soft skills. Also included will be field based / center based assignments to them to work in their respective ART centers e.g. on their routine data etc. This program will not only build individual capacities but will also establish institutional systems.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	Redacted	Redacted

Narrative:

Summary:
This project is mandated with a major goal of building organizational capacities through policy and systems strengthening, capacity development of future health care providers, program staff and managers, providing technical support and sharing information at various levels.

Few key aspects prioritized under this will be training systems, policy and capacity development of staff with systems in place of quality services delivery aimed at ensure standards of care packages for PLHIVs. Also prioritized will be aspects of logistics and supply chain systems management. The program will provide the above systems strengthening support at SACS as well as NACO level, providing high quality expertise for HIV care, treatment and ART service delivery program through evidence-based program planning. Agency will be responsible for facilitating systems for enhancing clinical capacity for HIV care and treatment services providers from govt. and private sector and establishing ART centers under the partnership model. Agency will focus on integrating the ART, Link ART, CCC and ICTCs through Continuum of Care model.

Agency through the activities listed below, will aim to achieve above stated broader goals of building organizational as well as human capacity for strengthening systems for HIV programming at District, State and National level in India.

Activity 1: Technical Assistance and Support to Centers of Excellence at the National level

The agency to partner with State and National government counterparts to provide technical support in the form of direct skilled manpower who are placed as Technical Consultants at the Centre of Excellence (COE) or an organization to organization TA. Based on program priorities and COE needs this support will be in critical areas of Care and Treatment services delivery, trainings and TA for operational research within the COE. This will aim to improve and strengthen the systems within the CoE for high quality program implementation, monitoring and review of the care, Support and Treatment components in line with the national guidelines under NACP III. The broader goal of this will be to establish sustainable systems with adherence to national guidelines and build in-house capacities of the Govt. and Program staff through mentoring, on-the-job training assistance and supportive supervision.

Some key areas that will be focused on:

a) Logistics and Supply Chain & Systems management including Patients flow management; Supplies, Logistics & Inventory; Staffing / HR & performance / turn-over issues; coordination / liaising aspects between various hospital departments housing ART centers with laboratory and other clinical departments and administrative wings.

b) TA for clinical aspects including quality of HIV care which includes both first line and Second line ART ,Adherence issues, Switch of regimen, TB-HIV; infection control, lab upgrades, Infection control and waste management, QA issues in diagnosis, treatment & care.

c) Facilitating staff capacity development thro Trainings for the various cadres of health care providers including Medical Graduates, Interns and Post Graduates.

d) Initiate other academic programs around the CoE for HIV/AIDS such as: Fortnightly journal clubs; Monthly CMEs; Monthly Grand ID rounds; periodic thematic integrated teaching sessions; periodic Guest lectures etc

e) TA for Operational Research

f) Provide TA in setting-up an HIV hotline for PLHIV support.

g) Will coordinate with the COE to initiate the State and / or National level HIV conference once in two years with multi-partner support, funding & NGOs
h) Will give TA to establish Virtual Resource Library utilizing the funds of COE
i) Will provide TA support to establish a Strategic Information Management Unit - basically a data management systems support at CoE level
Activity 2: Technical support to States and NACO for strengthening and providing high quality HIV care, treatment and ART services within the National program
Direct technical assistance through consultants as technical experts as well as organization to organization support at State and National level to build local internal organization staff capacities in planning, execution, reviewing and monitoring of Care, Support, Treatment and ART services delivery. Specific activities within this support include: 1) building interest in evidence-based program planning with a primary focus on the Treatment outcomes which will include both first line and Second line ART; 2) Review the data from the ART, Community Care Centers and Link ART with APSACS staff, relevant NGOs, and district staff for timely program modification and decision making; 3) integrating the data from the CCC, ART and the Link ART centers for a definitive outcomes from the ART program implementation; 4) Take lead in coordinating the activities in The COE as per the National Guidelines of COE; 5) Evaluate the functioning of the CCCs ,ART centers and Link ART centers in the State along with the Care Support and Treatment team of SACS and; 6) Disseminating critical operational issues based on the evidence from the field to opinion leaders and program managers.
Activity 3: Technical support for enhancing clinical capacity for HIV care and treatment services providers e.g. Doctors, Nurses both in the Public and Private sector
In India HIV/AIDS care and treatment services continue to be constrained by insufficient access to counseling and testing services, due to the low treatment literacy among health workers and the general population, stigma and discrimination among the providers being high as well as in Private sector, non-uniformity of services and non-conformity to the national strategies, lax or lack of systematic reporting systems in the private sector data generation and lastly challenging compilation and reporting.
To bridge the HIV skills and knowledge gap among practicing health-care providers both in the Public as well as Private sector, in-service HIV training courses will be undertaken as an immediate response to an acute need for rapid HIV prevention, care, and treatment scale-up, training needs have evolved over time. Training programs with innovative, feasible and acceptable methodologies need to be built to provide sta? with regular updates on HIV knowledge into in resource-limited settings.
Activity 4: Integration of Private sector HIV services delivery models into the National program including those for diagnosis, care, treatment and ART
To establish and strengthen a meaningful role for private sector involvement in HIV/AIDS services delivery more effectively to address the issues and needs at the State as well as National level particularly relating to Care ,Support and Treatment. The purpose is to work in tandem with the local host Government State AIDS Control Society (SACS) and NACO to expand HIV/AIDS program interventions

in the Private sector systematically and in an all inclusive manner bring the private sector into the fold of the public sector for delivering standardized HIV services as per the National guidelines.
This activity will also specifically facilitate networking of engaged and interested Private sector institutions to conduct training programs at the district level for physicians and nurses to manage PLHIVs in the private sector without stigma, Discrimination or Denial.
Activity 5: Establish ART centers under the partnership model
Concerted evidence based efforts to creatively advocate for and establish ART centers in the Private medical institutions as per the national protocols with funding support from the Government leveraging the existing resources from the Private sector, particularly to reach to the significant number of PLHIVs who seek services within the Private Sector and decongest the ART centers in public sector in order to enhance the quality of clinical services.
Activity 6: Establish and Operationalize of Link ART centers (LACs)
Will provide technical Assistance to the staff of LACs in terms of onsite mentorship and one to one interactions to tide over potential technical as well as operational barriers for implementation of quality program. The centers will be established in the existing Health system utilizing the services of existing human Resources the main obstacle would be lack of technical capacity of the staff in managing PLHIVs including OI and ART, Stigma and Discrimination, Documentation and data Management and weak supportive Supervision systems due to rapid scale up. On site mentoring would be the key strategy to establish LACs with TA addressing the above issues.
Activity 7: Model for integration of HIV care services between ICTC, CCC and an ART center in two select districts
To develop a model in lines with the principle of "Continuum of Care" at the district level. The model will focus on integrating the various facility based services that exist within the National program including Counseling and Testing centers, CD4 centers, CCCs and ART. The Centre of excellence will be the nodal centre to coordinate the activities as a tertiary facility that will coordinate trainings, supervision, review and mentoring of the peripheral service delivery units.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12404	**Mechanism Name: HS2020**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Abt Associates	
Agreement Start Date: Redacted	Agreement End Date: Redacted

TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 200,000	
Funding Source	**Funding Amount**
GHCS (USAID)	200,000

Sub Partner Name(s)

Deloitte Touche Tohmatsu		

Overview Narrative

Implementing Mechanism Narrative

Health system weaknesses are among the most important factors contributing to the sub-optimal use of priority health services. Health Systems 20/20 applies new and proven interventions in financing, governance, operations, and capacity building to strengthen health systems in order to increase use of priority services. Consumers, providers, and public health officials, face multiple challenges that can be addressed to prevent disease, improve health, and save lives.

Health Systems 20/20 takes a holistic approach to the health system by addressing its weaknesses comprehensively—attending to the technical areas of financing, governance, and operations while building sustainable capacity for addressing system issues. Health Systems 20/20 works across the globe on thematic issues ranging from HIV/AIDS, MCH, and family planning/reproductive health. These issues are addressed through several mechanisms: improving health financing mechanisms to spread health costs across a diversified population group; introducing performance incentives to improve quality and improve utilization; strengthening human resource management to improve the quality and number of human resources for health; institutionalizing National Health Accounts to help governments and stakeholders understand healthcare expenditures and better plan for the financing of healthcare; improving accountability measures within health stakeholders to improve the transparency and governance of health systems; and providing global leadership on health system strengthening activities.

From 2003-07, the Health Systems 20/20 team provided technical assistance and training support to the Government of India and the insurance regulator in the area of heath insurance. The team worked closely with the regulator, microfinance institutions (MFIs), insurance companies, the Actuarial Society of India, and network organizations in the area of health insurance. Currently the team is providing technical assistance to the Government of Uttar Pradesh (U.P.) in the design and implementation of a pro-poor

comprehensive health financing program. Health System 20/20 project is led by Abt Associates and implemented in conjunction with several key partners, including Deloitte Consulting, RTI, and TRG, among others.

In FY 10, HS20/20 will continue to collaborate with PSI CONNECT in the development of conducive policy environment for the promotion of innovative health insurance models that has PLHIV as a part of inclusive risk pools.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Increasing women's access to income and productive resources

Budget Code Information

Mechanism ID:	**12404**		
Mechanism Name:	**HS2020**		
Prime Partner Name:	**Abt Associates**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	OHSS	200,000	

Narrative:

NEW ACTIVITY NARRATIVE

SUMMARY
The overall purpose of the program is to collaborate with PSI CONNECT in the evidence-based promotion of risk pooling as a key mechanism for enhancing access to healthcare by people living with HIV/AIDS (PLHIV). HS 20/20's collaboration with PSI CONNECT will both tap into its specialized expertise in health financing and also ensure harmonization of USG assistance in the area of financial protection to PLHIV against high costs of healthcare. The purpose will be achieved in two ways:
(a) Bring in health insurance domain related expertise to develop a critical evidence base for PSI

CONNECT to engage government policy-makers, service providers, insurers and other stakeholders to help create an enabling environment for PLHIV health insurance; and (b) Provide strategic health insurance related expertise to USG partners in the design and implementation of innovative models of PLHIV insurance that will in turn inform the engagement with the stakeholders. The aim is to provide more health financing options to PLHIV and to distribute these costs among a diversified risk pool. This will lead to increased health insurance coverage and reduced out-of-pocket expenditures for PLHIV enabling them and their family members to lead economically productive and dignified lives.

HS 20/20 will build upon the collaborative efforts with PSI CONNECT and other USG partners in Year One in the design and implementation of innovative health insurance schemes for PLHIV. This would be with focus on developing various models of health insurance that do not exclude PLHIV and provides coverage for the opportunistic infections and other health concerns faced by PLHIV. HS 2020 would develop linkages to access regional and international expertise to provide evidence for strengthening/refining/disseminating efforts of USG partners' health insurance initiatives for PLHIV.

ACTIVITIES AND EXPECTED RESULTS

ACTIVITY 1: Provide health insurance related expertise in the design and implementation innovative and cost effective health financing models for PLHIV.

In FY09, HS20/20 collaborated with PSI CONNECT and other USG partners to have more informed and evidence based discussions/ engagement with the stakeholders on health insurance for PLHIV.

In FY 10, HS 2020 will continue to collaborate with PSI CONNECT and the partners in the design and implementation of innovative models of health insurance that address some of the operational and cost concerns of insurers and federal and state governments that are currently implementing health insurance schemes for low-income individuals and households in general population. The program will work directly with PSI CONNECT, the insurance regulator, interested insurance companies in the public and private sector, NGOs and microfinance institutions (MFIs) who are providing or willing to provide health insurance coverage to PLHIV. HS 20/20 will also collaborate with PSI CONNECT to engage NACO and public stakeholders in the design of appropriate risk funds to facilitate larger insurance coverage to PLHIV. In FY 10, the focus of the program will be on working towards mainstreaming PLHIV insurance into health insurance schemes for the general population while also exploring the scope for alternate models.

HS20/20 will work with PSI CONNECT, the insurance regulator, insurance companies to develop/adapt and refine various models of health insurance for PLHIV in areas such as benefit package design,

pricing, enrollment, risk sharing, database on PLHIV morbidity and health seeking behavior, and the impact assessment of various health insurance models. The technical assistance will also explore the scope of a performance-based incentive program within the health insurance model that will help address the quality of service issue.

In addition HS20/20 will continue its collaboration with PSI CONNECT to engage stakeholders such as the National AIDS Control Organization (NACO), positive networks, insurance companies, the insurance regulator, providers, and healthcare / microfinance NGOs to address both demand and supply side related issues in PLHIV insurance. HS20/20 technical assistance will also build capacity of NGO/MFIs/Corporate sector in the design and implementation of sustainable health insurance models for PLHIV.

Expected Result
The expected result of this activity is greater understanding of issues and options in the provision of financial risk protection to PLHIV through health insurance mechanisms as demonstrated by the increased engagement of the insurance sector in PLHIV health financing.

ACTIVITY 2: Assist USG partners in documentation and dissemination of lessons on engaging the insurance sector.

In FY09, HS20/20 worked with USG partners to strategize on the consolidation of evidence based documentation and lessons on health insurance for PLHIV.

In FY 10, HS 20/20 will build upon the initial work undertaken in year one and support key USG partners in documentation of the experience of working with multiple stakeholders on increased engagement of the insurance sector with PLHIV. This will be achieved through technical support in translating the institutional knowledge bank into an effective dissemination document that will inform the programs of the National AIDS Control Organization (NACO), National Rural Health Mission (NRHM), State AIDS Control Societies (SACS), other USG partners and PLHIV Networks in the area healthcare financing for the poor. The outcomes of FY09 provided more evidence for further developing a compendium resource tool on PLHIV health insurance in FY 10.

Expected Results
Increased engagement of NACO and other government agencies working in health sector in general and HIV/AIDS in particular, insurers, the insurance regulator, and other stakeholders ((including the policy makers and implementing partners) to sustain the provision of PLHIV insurance.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12405	**Mechanism Name: AIDSTAR 1**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: AIDSTAR I, Task Order#1	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 2,100,000	
Funding Source	**Funding Amount**
GHCS (USAID)	2,100,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The AIDSTAR-One program is a mechanism under the umbrella of the indefinite quantity contract (IQC) AIDS Support and Technical Assistance Resources (AIDSTAR) managed out of the Office of HIV/AIDS in USAID's Bureau for Global Health. The mechanism is implemented by a consortium of partners led by John Snow Inc. that includes BroadReach Healthcare (BRHC), EnCompass LLC, GMMB Inc., International Center for Research on Women (ICRW), MAP International (MAP), mothers2mothers (m2m), Social & Scientific Systems, Inc. (SSS), the University of Alabama at Birmingham (UAB), The White Ribbon Alliance for Safe Motherhood (WRA), and World Education, Inc. (WEI).

The primary focus of AIDSTAR-One is to provide technical assistance (TA) services to the Office of HIV/AIDS and PEPFAR country teams in knowledge management, technical leadership, program sustainability, strategic planning and program implementation support across the range of HIV/AIDS technical areas. The four major components of AIDSTAR-One are:

1. Knowledge Management: to create, synthesize, manage and disseminate a knowledge base of tested approaches and good and promising practices in HIV program implementation in support of PEPFAR goals.
2. HIV Prevention, Care and Treatment: to advance and support state-of-the-art program strategies to prevent HIV transmission, and provide care and treatment services to those infected and affected by HIV.

3. Policy, Systems Strengthening and Sustainability: to provide TA to strengthen systems, support policies and develop guidelines to promote sustainable HIV prevention, care and treatment programs at the country level, including modes of service delivery that are cost effective and sustainable.
4. Field Support-funded program implementation (primarily for non-focus countries): to support USG country teams by implementing programs that help meet country-level targets and contribute to broader goals of PEPFAR.

Specific strategies and approaches that are implemented by the AIDSTAR-One team include:
• Targeted surveying of HIV experts and implementers;
• Innovative uses of new and existing technologies to disseminate information; and
• Fostering collaborative technical leadership and knowledge management.
The program also facilitates the categorization of practices and programs by variables such as geographic region/country, epidemic stage, target population, service delivery type, as well as identifying it as a good, promising practice.

Additionally, the AIDSTAR-One Good and Promising Programmatic Practices database offers planners and managers access to information to design and implement effective programs, building on the experience of others. Technical briefs and case studies in key areas synthesize the program experience to date, with a focus on essential components of prevention programs that build toward effectiveness and scalability. Through the provision of short- and long-term TA, AIDSTAR-One enables USG-funded HIV/AIDS prevention programs and activities to work with their partners at the country level to develop their own evidence-driven strategies and implementation plans.

AIDSTAR-One also serves as a leading resource in HIV treatment for USAID and other USG agencies and partners. It provides a platform for global technical leadership and knowledge management in mental health, care and support integration, and evaluation of program efforts to integrate nutrition support into faith-based programs. Additionally, it supports plans to strengthen the programmatic content, quality and sustainability of service delivery in existing HIV treatment programs.

Other areas for TA include long- or short-term TA for:
• Program implementation support in specialized HIV/AIDS technical areas;
• In-country support for coordination and scale-up for HIV/AIDS activities in support of USG country strategies;
• Documenting and disseminating successful innovative approaches and sustainable models, evidence-based best practices, and lessons learned; and
• New approaches, tools and methodologies in HIV/AIDS programming.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12405**		
Mechanism Name:	**AIDSTAR 1**		
Prime Partner Name:	**AIDSTAR I, Task Order#1**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	OHSS	2,100,000	

Narrative:

SUMMARY

AIDSTAR-One with its mandate to provide short or long-term Technical Assistance (TA) in knowledge management, technical leadership, program sustainability, strategic planning and program implementation support across the range of HIV/AIDS technical areas will serve as a mechanism to strengthen the overall USG response to HIV/AIDS in India.

The third phase of the $2.5 billion National AIDS Control Plan III (NACP III; 2006-2011) is implemented by the National AIDS Control Organization (NACO). NACP III outlines an ambitious time-line to deliver large-scale outcomes, e.g., prevention interventions at over 2,000 sites for most at risk populations (MARPs) across 31 states; free antiretroviral (ARV) treatment through more than 200 centers; and counseling and testing(CT) services at more than 4,500 sites across India. The newly established District AIDS Control Units (DAPCUs) aim at decentralizing HIV/AIDS management and control to the district level. The USG team contributed to the design and implementation plan of NACP, III and is actively involved in its roll out. The USG participates in several national technical working groups (TWG) on prevention, care and treatment, laboratory strengthening, behavior change communication (BCC) and orphans and vulnerable children (OVC). The USG provides TA to strengthen health systems in India through a spectrum of activities that intersect virtually all technical areas. As NACP III is scaled up rapidly

with high intensity of activities for implementation, there is a commensurate need for TA for scale-up, project management, quality of interventions and monitoring and evaluation. In addition, the initiation of operations at the district level and focus on decentralization has increased the need for targeted TA to assist NACO and SACS in building district level programs.

The primary audience for outcomes provided through this mechanism will be USAID in addition to other stakeholders such as NACO, the State AIDS Control Societies (SACS) of USG priority states and USG partners.

ACTIVITY1: Provide TA to NACO, SACS and USG partners in emerging technical areas.
The scale-up of the NACP III has highlighted the need for targeted TA in key technical areas of strategic information, institutional capacity building, human resources for health and convergence. Under this activity, the project will provide TA to strengthen systems, support policies and develop guidelines to promote sustainable HIV prevention, care and treatment programs at the country level, including modes of service delivery that are cost effective and sustainable. The TA will assist NACO, SACS, DAPCUs and USG partners in specific technical areas including improving quality assurance systems for delivery of HIV/AIDS related programming and services, including prevention. The NACP III has articulated the need for a greater engagement of the private sector in HIV/AIDS programming. The TA will also support the development of guidelines that facilitate private and commercial sector delivery of HIV/AIDS. Additionally, the TA will assist in developing an exit strategy for the USAID supported Technical Support Units (TSUs), which are tasked to build capacity of the various SACS in scaling the national program. This will include development of transition milestones as part of assessing the transfer of skills from the TSUs to the SACS in various program and technical areas such as:
• Strategic planning, program management and monitoring and evaluation;
• Community-based management of prevention, care and treatment programs;
• Human resource management;
• Financial management and procurement skills;
• Evidence-based micro-planning for working with most-at-risk populations (MARPs);
• Development of annual action plans at state level and district action plans in high-burden districts of USG-priority states based on data triangulation and evidence;
• Assessment and improvement of quality of prevention and care and treatment programs; and
• Monitoring and measurement data quality audits.

The project will also support the capacity building of state-level institutions in USG priority states in the development and utilization of strategic information for program planning, such as triangulation and implementation of behavioral surveillance among MARPs using bio-markers. Other areas will include assistance in strengthening existing HIV treatment programs specifically focusing on assessments of

cotrimoxazole supply chain and assessment of program-based care and support monitoring and evaluation activities as well as supporting the expansion of palliative care activities at the facility-based care and support programs.

The mechanism will assist in conducting high quality operations research in areas related to social and behavioral research to fill critical gaps of knowledge and evidence at the national and state level. The topics selected will have implications for interventions and policies such as research to prevent or reduce alcohol use and sexual risk; assessment of private sector innovations in HIV/AID programming; and operational feasibility of convergence between selected functions and functionaries of two health systems of the National Rural Health Mission (NRHM) and NACP III.

ACTIVITY 2: Documentation of Good & Promising Programmatic Practices (G3Ps) of the India USG program
AIDSTAR-One is mandated to identify and categorize practices and programs related to HIV/AIDS prevention, treatment, care and support that include variables such as program content, geographic region/country, epidemic stage, target population, service delivery type, as well as identifying good and promising programmatic practices. In FY10, the project will assist in documentation of select programs supported by USG in India, which will also augment the requirements for their closeout. As part of its documentation, it will consolidate the lessons learned and plan a strategy for its nationwide dissemination. These inputs will also inform the India USAID mission in its preparation for a roadmap for high quality HIV/AID programming in the development of state and regional strategies as part of its strategic redesign. (See IMN and BC narrative under GH-TECH mechanism, also submitted for FY10 COP).

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12406	**Mechanism Name: GHTECH**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: GH Tech	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 989,272

Funding Source	Funding Amount
GHCS (USAID)	989,272

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Global Health Technical Assistance (GH Tech) project which was announced in February 2005 provided the Global Bureau for Health (GH) at the U.S. Agency for International Development (USAID), with high-quality independent technical support for design, monitoring, and evaluation of health, population, and HIV/AIDS activities. Under this contract, the awardees included a consortium of partners led by the QED Group, which comprises LLC, CAMRIS International, and Social and Scientific Systems, Inc. (SSS). The project facilitated support to USAID's health programs through technical assistance (TA), global health program and research management secretariat, mission support and logistical support. The project provided the USAID GH, regional bureaus and missions with flexible access to a range of technical and managerial expertise to design, monitor, and evaluate program activities.

Some of the successful activities undertaken by GH-TECH in various countries include the evaluation of the private sector program, mid-term evaluation of the PEPFAR integrated Management of Adolescent and Adult Illness Project and evaluation of the High-Risk Corridors Initiative in Ethiopia and the midterm evaluation of Forte Saude Project in Mozambique. The project consortium also completed several assignments for GH including the strategic appraisal of the ACQUIRE Project and operational plans for data quality assessments in Malawi. In India, the GH-TECH project assisted in the evaluation of the Innovations in Family Planning Services (IFPS-II) Project that helped develop a detailed performance management plan that allowed IFPS II management to oversee TA effectively, plan future activities, and communicate results to a broad and varied audience.

The GH-TECH project has worked with private-sector clients, US agencies and overseas governments, international donors, and private voluntary organizations and nongovernmental organizations (NGOs) in the United States, Europe, the former Soviet Union, Africa, Asia, the Middle East and Latin America and will end in October 2010.

The follow-on to this project is expected to be announced by September 30, 2009. The focus of the follow-on mechanism is expected to propose continued high-quality independent technical support for design, monitoring, and evaluation of health, population, and HIV/AIDS activities. The USG India intends to use this proposed new mechanism to undertake specific activities related to redesigning the USAID

India HIV/AIDS portfolio to reflect emerging priorities and address them within the national and sub-national context.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12406**		
Mechanism Name:	**GHTECH**		
Prime Partner Name:	**GH Tech**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	OHSS	989,272	

Narrative:

SUMMARY

The third phase of the $2.5 billion National AIDS Control Plan-III (NACP III; 2006-2011) is implemented by the National AIDS Control Organization (NACO). The NACP III outlines an ambitious timeline to deliver large-scale outcomes, e.g., prevention interventions at over 2,000 sites for most-at-risk populations (MARPs) across the country; free antiretroviral (ARV) treatment through more than 200 centers; and counseling and testing(CT) services at more than 4,500 sites across India. The newly established District AIDS Control Units (DAPCUs) aim at decentralizing HIV/AIDS management and control to the district level. The USG team contributed to the design and implementation plan of NACP III and is currently actively involved in its roll out. The USG participates in several national technical working groups (TWG) on Prevention, Care and Treatment, Laboratory Strengthening, behavior change and communication (BCC) and orphans and vulnerable children (OVC). The USG provides technical assistance (TA) to strengthen health systems in India through a spectrum of activities that intersect virtually all technical areas. As NACP III is scaled up rapidly, NACO has determined that institutional capacity building at state and regional levels is the long-term mechanism for ensuring sustainable

resources for an expandable response to the currently concentrated epidemic.

The USAID response to the HIV/AIDS epidemic in India has been spearheaded through the HIV/AIDS Division of the Population, Health and Nutrition office, which conceptualized and facilitated the implementation of the first comprehensive HIV/AIDS project, the AIDS Prevention and Control (APAC) Project in 1992. The reversal of the HIV epidemic in the state of Tamil Nadu can be attributed to over fifteen years of significant USAID support for direct interventions through the APAC project. Subsequently, USAID made substantial investments in other high prevalence states such as Maharashtra. Its geographic areas of coverage expanded in 2006 to Karnataka and Andhra Pradesh in response to the state government's request for similar support for demonstrating quality programming and provision of high quality TA.

Over the years, the wealth of experience in community-based programming, the leadership role in private sector programming and a very strong partner network of diverse skills have helped to build the technical excellence in the HIV/AIDS portfolio of USAID. Since the roll-out of NACP III, the USAID HIV/AIDS portfolio has expanded to included technical expertise in prevention programming among MARPs, care, support and treatment programs with comparative advantages in private-sector partnerships, strategic information, BCC and strengthening health systems at national, state and district levels.

USAID is also experiencing an internal transition that refocuses its developmental lens towards sustainable and scalable systems. To provide leadership that harnesses the extensive health and developmental expertise, the mission intends to maximize state-of-the-art HIV/AIDS programming through strategic leadership, technical excellence, cutting edge research and an expanded partnership for development. In response to NACP-III's emphasis on repositioning donor support for systems strengthening and targeted TA, USG investments are also increasingly transitioning from direct support for field-level implementation to providing more technical and management assistance at higher levels to NACO and the State AIDS Control Societies (SACS). At the India PEPFAR Program Review debrief, the Government of India articulated the need for a USG role in areas of comparative advantage such as program management, communication, strategic information, private-sector partnerships and health systems strengthening including human capacity development. New emerging areas of priority are institutional capacity building, human resources for health, supply chain management and convergence.

Additionally, most of the HIV/AIDS projects under the current USAID India portfolio will close out in the next couple of years. There is a need to develop a redefined portfolio to effectively respond to the context of the Indian epidemic, while aligning with NACP III and PEPFAR-2 priorities. In this context, TA in FY10 is sought through the GH-TECH follow-on mechanism to facilitate the realigning of the USAID India HIV/AIDS portfolio to reflect these emerging priorities and address them within the national and sub-

national context. This will lead to a clear articulation of the proposed technical and geographical priorities, strategic objectives and implementation mechanisms designed to address them.

The primary audience for outcomes provided through this mechanism will be USAID in addition to other stakeholders such as NACO and the state AIDS control societies (SACS) of USG priority states.

ACTIVITY 1: Assist USAID in the preparatory phase of designing the USAID HIV/AIDS strategy to align with emerging priorities

As part of realigning the USAID India HIV/AIDS portfolio to the global mission of technical excellence and expanded partnership for development, the mechanism will provide TA for assisting USAID in a preparatory phase that involves gaps analysis and other exercises to inform the structure and design of the USAID India HIV/AIDS portfolio. Specifically, the project will:
1. Support gaps analysis assessments and other required reviews, which will input into a specific roadmap for designing the overall portfolio
2. Facilitate internal and external environmental analysis to identify national and regional priorities and gaps in strategic HIV/AIDS programming
3. Determine the viability of restructuring of the HIV/AIDS portfolio through state or regional level programming versus cross-cutting thematic approach

ACTIVITY 2: Support the design of a strategic framework and determine scope of work for the restructured USAID India HIV/AIDS portfolio

The mechanism will support the USAID India HIV/AIDS team in analyzing the recommendations of the various exercises undertaken under Activity 1 (stated above) that will inform the development of a strategic framework for the revised HIV/AIDS portfolio. The project will work in close collaboration with the USAID India HIV/AIDS team for implementing a series of activities related to the strategic framework. Specifically, the mechanism will:
1. Determine design of potential USAID HIV/AIDS programming with specific recommendations towards a road map for a national level strategy that aligns the global, national and PEPFAR priorities;
2. Facilitate the development of regional or state-level strategies and activities as determined under the framework of the national strategy;
3. Support the redesign of the existing projects including, but not limited to, the bilateral Avert project in Maharashtra;
4. Develop the request for proposals and request for applications for new awards that is informed from the realigned HIV/AIDS portfolio; and

5. Support the supplemental activities for the award of the new grants.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12407	**Mechanism Name: Measure DHS**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Macro International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 500,000	
Funding Source	**Funding Amount**
GHCS (USAID)	500,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Implementing Mechanism Narrative

The MEASURE program implemented by ICF Macro is a headquarters managed mechanism to improve the collection, analysis and dissemination of data for use in planning, policy-making, managing, monitoring and evaluating health, population, HIV and nutrition programs.

ICF Macro has provided technical assistance (TA) for the 1992-93, 1998-99, and 2005-06 rounds of the National Family Health Survey (NFHS). NFHS is a large-scale, multi-round survey, conducted under the stewardship of the Ministry of Health and Family Welfare, Government of India (GOI). All NFHS surveys have included extensive program-relevant information about the knowledge of AIDS and the most recent survey (NFHS-3) greatly expanded the HIV/AIDS content and also provided the first HIV prevalence estimate among the general population in India.

Key Ongoing Activities:

• Providing TA and building capacity of the International Institute of Population Sciences (IIPS) and more than 25 field organizations to design and conduct high-quality, national household surveys on health, HIV/AIDS, population, and nutrition throughout India;
• Producing field manuals (including manuals for collecting, storing, and transporting blood samples, for HIV testing, and for the safe disposal of bio-hazardous material), laboratory manuals and protocols for HIV testing;
• Providing TA in biomarker measurement, including testing blood for HIV.

Key Achievements and Innovations:

• NFHS-3 provided the first ever HIV prevalence estimates among the general population of India and for five of the six high prevalence states and Uttar Pradesh. This information has been instrumental in providing more accurate national and global estimates of HIV burden and providing a calibration factor for adjusting annual HIV estimates from the surveillance system.
• NFHS-3 provided key information about some of the potential causes of the spread of HIV, including high-risk sexual behavior and the frequency and safety of medical injections. For the first time, the survey included information on men and never married women to give a more complete picture of HIV/AIDS in India.
• The National AIDS Control Organization (NACO) decided to introduce Dried Blood Spot (DBS) blood collection and testing in the HIV Surveillance System in all surveillance sites throughout India, using the same methods employed in NFHS-3. ICF Macro provided technical support to the NACO surveillance staff on this methodology.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	20,000
Human Resources for Health	30,000

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection

Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**12407**		
Mechanism Name:	**Measure DHS**		
Prime Partner Name:	**Macro International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	HVSI	500,000	

Narrative:

NEW ACTIVITY NARRATIVE (FY2010)

SUMMARY

The NFHS are large-scale, nationally-representative household surveys that focus on health (including HIV/AIDS), population, and nutrition. In FY2010, the MEASURE Demographic Health Survey (DHS) Phase III project, implemented by ICF Macro, will provide TA for implementation of the fourth round of NFHS-4, including HIV/AIDS knowledge, attitudes, and behavior component of the individual interviews, collection of blood for HIV testing, selection and validation of HIV test kits, ethical approvals, and laboratory procedures. The survey will be carried out in every state in India and will provide estimates of key indicators at the state and national level for monitoring and evaluating programs and for providing critical input for policy and program decisions.

ACTIVITIES AND EXPECTED RESULTS

ACTIVITY 1: TA for NFHS-4 will provide estimates for key health and HIV indicators for evidence-based policy-making and programming.

Fieldwork for NFHS-4 is expected to begin in 2011 after the completion of the Indian census. An 18-month planning period is typically required to plan and make arrangements for a large-scale, multi-

dimensional survey of this type that is likely to involve collaboration among more than 30 implementing agencies, government ministries, funding agencies, NGOs, and other organizations.

In FY 2009, ICF Macro provided TA for the NFHS-4 primarily in preparing the study protocol, identification of implementing partners, funding agencies and finalizing agreements. During this period, consultations were held with GoI and other key counterparts to finalize the content of the survey as well as the biomarkers to be tested. Assessing the requirements for the protection of human subjects and other ethical considerations and designing quality control mechanisms for survey implementation were undertaken during this phase.

In FY 2010, ICF Macro will continue to provide TA for NFHS-4, primarily in the following areas for the collection, analysis and dissemination of HIV data:

• Selection of key survey staff
• Sample design and implementation
• Questionnaire design and translation into 20 languages
• Preparation of field manuals for interviewers, supervisors, and household listing and mapping staff
• Preparation of a manual for blood collection and biomarker testing
• Preparation of protocols for the review of human subjects' protection by IRBs
• Selection of implementing agencies for the fieldwork
• Conducting a pretest of all survey procedures
• Training of trainers for interviewers and supervisors
• Training of health investigators who will collect blood for biomarker tests
• Household listing and mapping operations
• Identification of suppliers for biomarker supplies and equipment
• Procurement of biomarker supplies and equipment
• Validation of HIV test kits and tests for other biomarkers
• Implementing data quality controls
• Arranging for laboratory testing of blood samples for HIV
• Preparation of a tabulation plan
• Data entry and editing
• Data processing
• Calculation of sample weights
• Production of tables for the preliminary report
• Writing and dissemination of the preliminary report

Expected Results:

The data collected in the survey will provide key information for evidence-based decision-making in a wide variety of areas, including knowledge and attitudes about HIV/AIDS, HIV prevalence and high-risk sexual behavior. The wealth of data available from the survey will allow HIV/AIDS to be examined in the context of related information on health, population, and nutrition. The reputation of the NFHS surveys for the collection of consistently high-quality data, and the increasing ownership of the survey by the GoI and other organizations, insures that the data collected will be fully and productively utilized to improve HIV programs.

With respect to sustainability, the NFHS surveys have already trained thousands of interviewers, supervisors, health investigators, survey designers, data processing personnel, and communication experts, many of whom are currently engaged in strategic information roles in HIV programs. NFHS-4 will continue to emphasize capacity-building in conducting high quality health and HIV surveys through on-the-job training, institutional development, and collaboration on research, analysis, and communication activities.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12408	**Mechanism Name: Project Search-Boston University**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Boston University	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 450,000	
Funding Source	**Funding Amount**
GHCS (USAID)	450,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Implementing Mechanism Narrative

Project SEARCH (Supporting Evaluation and Research to combat HIV/AIDS) is a multiple award indefinite quantity contract (IQC) to support HIV/AIDS research and evaluation worldwide.

Project SEARCH Task Order for orphans and vulnerable children (OVC)-CARE aims to carry out research and evaluation to improve the coverage, quality and effectiveness of HIV/AIDS prevention, care and treatment programs worldwide. It also aims to strengthen local capacity in HIV/AIDS research and public health assessments.

This Task order focuses on improving coverage and quality of OVC programs in developing countries with the aim of filling critical gaps in OVC research and guiding the alignment of OVC programs to complement national level responses.

Rationale

Of the 2.31 million people living with HIV in India, children account for 3.5%. The third phase of the National AIDS Control Plan (NACP III) aims to halt and reverse the epidemic in India from 2007 to 2012. In addition to a focused prevention program, provision of care, support and treatment to a large number of people living with HIV/AIDS including children infected and affected by HIV/AIDS, is well articulated in the plan. In the long term, the goal is to achieve the highest quality of life for HIV-infected and affected children and their families through delivery of a comprehensive package of services. The Policy on Children and HIV/AIDS released by NACO and Ministry of Women and Child Development (MWCD) in 2007 provided a reference to the operational guidelines developed by the National Task Force for Children affected by HIV/AIDS . The Policy lays down a life cycle approach with a goal to provide a sustainable and integrated system of HIV prevention, counseling, testing, care and support to ensure that children who are most vulnerable to HIV infection or who are HIV positive or otherwise affected by HIV/AIDS. It aims to ensure that such children enjoy the same benefits and opportunities as all other children to develop their full potential.

However there is no system to estimate and track the number of OVC either for the country or the states that can inform programming and resource allocation. There is a need for a more scientific and accurate estimation of OVC. The OVC programming area is still evolving in India and there is an urgent need for OVC related research. The final research agenda will be further refined based on discussions between Boston University and PEFAR India teams.

USAID India will access Field Support through this task order. This will be a new a new mechanism and

will be the first year of funding for BU.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Child Survival Activities

Budget Code Information

Mechanism ID:	**12408**		
Mechanism Name:	**Project Search-Boston University**		
Prime Partner Name:	**Boston University**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	450,000	

Narrative:

SUMMARY

USG is planning to access the Field Support Mechanism for the Task Order for the OVC –CARE Project which has been awarded to Boston University. USG is planning to use this Task Order to improve coverage and quality of Orphans and Vulnerable Children programs in India. The current lack of research and comprehensive evaluation of the effectiveness and efficiency of various types of OVC interventions in India will be filled to a large extent by this Task Order. The OVC programming area is still evolving in India and there is an urgent need for OVC related research in India. The final research agenda will be further refined based on discussions between BU and PEFAR India teams.

In FY10 quality assurance will be a priority in USG -OVC program planning and implementation. Under the Boston University CHID –OVC Care project the following key activities will be carried out to fill critical gaps in the evidence based programming:

ACTIVITY 1: Conduct OVC evidence-based research to guide cost-effective programming of OVC

resources.

OVC-CARE will ensure a comprehensive understanding of the needs of affected children and their families and better targeted responses by gathering evidence from the current USG OVC projects. The cost effectiveness of family centers care will be compared with child centered care. This body of evidence will include epidemiological data, such as prevalence and incidence rates of HIV. OVC CARE will also analyze data from DHS and other population- based surveys from sectors relevant to mitigating impacts of HIV/AIDS. Based on the findings of these assessments OVC programming will be redesigned and made more cost effective.

ACTIVITY 2: Identify strategies and approaches that will improve coverage, quality, effectiveness and impact of OVC programs

The assessments conducted by OVC-CARE will identify strategies and approaches that are promising practices achieving positive outcomes in child wellbeing. The project will identify replicable, cost -effective mechanisms that will prioritize family and house-hold centered approaches as well as focus on sustainable responses ensure the health, nutrition, psychosocial wellbeing, education, protection and economic support of orphans and vulnerable children.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12409	**Mechanism Name: Strengthening Pharmaceutical Systems (SPS)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Management Sciences for Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 250,000	
Funding Source	**Funding Amount**
GHCS (USAID)	250,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

USAID awarded Management Sciences for Health (MSH) its five year Strengthening Pharmaceutical Systems (SPS) program in 2007 as follow-on to its Rational Pharmaceutical Management plus program. The mandate of the SPS program is to build capacity within developing countries to effectively manage pharmaceutical systems, and ultimately impact on saving lives by improving access to and use of medicines of assured quality.

The SPS program focuses on achieving four key results:
1. Improving governance in the pharmaceutical sector;
2. Strengthening pharmaceutical and laboratory management systems to support public health services/interventions;
3. Containing the emergence and spread of antibiotic resistance; and
4. Expanding access to essential medicines.

SPS programs assisted in improving medicines policies, regulation, quality assurance and pharmacovigilance in Africa and south East Asia. The program applied the pharmaceutical care concept in resource-limited settings of sub-Saharan African countries. In addition to providing global technical leadership through their consortium partners such as the WHO collaborating center in Pharmaceutical Policy at the Harvard University, the program also draws specialized resources from the London School of Hygiene and Tropical Medicine and the African Medical Research Foundation.

India has a robust $2.5 billion National HIV/AIDS program (The National AIDS Control Plan/NACP-III) with a primary focus on prevention of new infections in high risk groups. There is a commitment under NACP-III to strengthen the infrastructure, systems and human resources in prevention, care and treatment at the district, state and national levels. While the public health care delivery system is fairly well defined, the private health sector offers an alternate rapid health care delivery system. There is widespread agreement that though the government has the necessary resources (financial, human and equipment); the health outcomes remain relatively poor. The key challenges include inefficient use of resources, poor quality of health delivery services and federal-state dynamics, as health is a state subject. Overall, there is inadequate information on key variables in the health service planning process such as forecasting demand, cost analysis, existing resources in the health market, quality of services, and utilization of services. Additionally, there is insufficient effort to make this information available at sub-national levels or provide technical assistance in the use of such data.

Currently, the National AIDS Control Organization (NACO) provides financial assistance for supplies, drugs and medicines for opportunistic infections, STI and PMTCT services to various district hospitals through the state level State AIDS Control Societies (SACS). The scaling of CT services across nearly 5,000 centers in India translates into a base requirement for about 22 million tests a year in the public sector. The main HIV Rapid Testing kits are procured at the federal level while the confirmatory test kits are procured at the state level. Additional procurement requirements include the supply of first line ARV drugs that are supported through the Global Fund for at least 150,000 who are currently on ART. NACO intends to cover 300,000 adults and 40,000 children on ART by 2011.

States which have a high burden of HIV such as Karnataka, a USG priority state, have a need for stronger pharmaceutical management including a systemic regulation for selection, procurement, distribution and use. For instance, the state has 33 fully functional ART centers with close to 30,000 patients on ART. As in other USG priority states, each of these centers performs a spectrum of functions ranging from dispensing of ART and adherence counseling to basic laboratory investigations and networking with other services. There is a need for accreditation of ART centers for improved delivery of high quality services and human capacity building at all levels from drug distributors and stockists, to pharmacists and health care providers, including those from the private sector.

Under the public-private partnership initiative of NACP-3, comprehensive antiretroviral therapy (ART) centers with amenities for HIV care services are being initiated in the private sector including private medical hospitals to expand the base of service delivery for HIV care and treatment. However, assessments in high HIV burden states indicate that almost 30% of general practitioners in the private sector who see HIV patients prescribe ART, with the medical/pharmaceutical representative as the only source of information. Similarly, there is no system to calculate the volume of ART being dispensed in the private sector or system for a decentralized procurement of opportunistic infection (OI) drugs and essential laboratory supplies at the district level.

The need of the hour is to provide a model for applying systems strengthening interventions that are most appropriate for India's specific health, economic and political situation that would also address gaps at the state level systems.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

TB

Budget Code Information

Mechanism ID:	12409		
Mechanism Name:	Strengthening Pharmaceutical Systems (SPS)		
Prime Partner Name:	Management Sciences for Health		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	OHSS	250,000	

Narrative:

SUMMARY

SPS with its mandate to provide technical assistance (TA) for building country capacity will serve as a mechanism to fulfill the gaps existing in the pharmaceutical management functions and services in USG priority states where the burden of HIV is high. While antiretrovirals (ARV) are centrally procured, the states perform key procurement functions for certain HIV test kits and drugs for OIs and sexually transmitted infections (STIs) as part of the decentralization process. Some of the USG priority states which have high HIV burden of care and treatment lack the infrastructure, management systems, information technology as well as experienced and competent staff to plan and implement an efficient procurement system. Additionally, the capacity building of the private sector for rationale use of ARV is a gap that is not yet addressed.

USG intends to work in close collaboration with MSH, the implementing agency for SPS to design and implement potential contributions in improving the state level responses for efficient HIV care, support and treatment services. The project intends to address the state specific gaps in the USG priority states including gaps in quality of services, barriers for treatment adherence and initiating pharmacovigilance systems. Drug safety is also a priority issue for research and post-market adverse drug reaction (ADR) monitoring is emerging as a key for determining a structured analysis of clinical patterns and morbidity associated with antiretroviral therapy (ART).

The project envisages working in close collaboration with the State AIDS Control Societies (SACS) and the local drug and logistics society and will leverage the government program where ART is dispensed in the public sector ART centers and where the treatment services are provided at the government ART and/or community care centers (CCC).

As part of the private sector engagement, NACO has initiated comprehensive ART centers with amenities for HIV care services in private medical hospitals with teaching institutions. This has expanded the base of service delivery for HIV care and treatment. The project will work to build capacity of such private sector institutions such as the Kempegowda Institute of Medical Sciences (KIMS) in Karnataka in improving quality of service of laboratories and delivery of ART services. Standard operating protocols (SOPs) to standardize the testing processes and laboratory functions in accordance with national and international standards will be a primary focus. The work with the private medical sector will be in collaboration with local associations such as the Indian Medical Association or the state chapters of the Nursing Home and Hospitals Association with joint agreements from the local SACS.

Activity 1: Provision of TA at state and district levels for improving quality of service of laboratories and pharmacies in delivery of ART services

Laboratory and pharmacy components are essential elements of an ART center. Efficient quality service comprising a full-spectrum of services is the cornerstone of effective ART. The rapid scale-up of ART under NACP-III, however has not balanced the commensurate quality of services. Current gaps include lack of data on current pharmacies and laboratory management systems in terms of their current manpower and knowledge, physical infrastructure, stock and dispensing procedures and protocols that are followed for inventory management, distribution, dispensing and forecasting. The key sub-activities that will be undertaken for improving the quality of pharmacies and lab services will include accreditation of ART centers. TA will be provided at selected state-headquartered ART centers and 30 district level ART centers across 5 USG priority states for the following:
a) Development of SOPs for laboratories and pharmacy services - This will bring in a standardization of testing procedures across the USG priority states and allow high quality and uniform interpretation of results. This TA will also be adapted to the regulation of testing for laboratories which have CD4 machines. Capacity building of the laboratory technicians in these laboratories for regular calibration, maintenance of the machines, trouble shooting, improving sensitivity of the CD4 machines, standardization of protocols, quality assurance procedures will contribute to the improved services of the ART center.
b) Designing and evaluation of tools of pharmaceutical medication for medication counseling and treatment adherence- Addition support will be provided to overcome the barriers in treatment adherence such as state specific pharmaceutical communication in an appropriate and technically sound manner commensurate with the patient's literacy skills and cultural context. Patient treatment charts will be designed and field tested to evaluate the patient's understanding of the pictograms on the adherence to

medication.

Activity 2: Establish pharmacovigilance systems

In FY 2010, TA will be provided in the high HIV burden state of Karnataka for establishing a pilot pharmacovigilance study at two sites to monitor adverse drug reactions. Treatment of TB in HIV infection presents several challenges including pharmacological interaction between antiretroviral s (ARV) and anti tuberculosis (ATT) drugs, overlapping toxicity profiles and clinical manifestations of non-adherence of complicated HIV-TB treatment regimens. In collaboration with the NACO-approved ART center at the private medical teaching hospital of KIMS, patients on ARV as well as those on ARV and concomitant treatment of TB will be monitored over a 12 month period in compliance with ethical and management protocols by national and international standards.

Activity 3: Capacity building of private sector including private providers and hospitals in the private sector

In FY 2010, a total of 500 medical practitioners from priority USG states will be trained in the rational prescription of ART. The project will partner with KIMS, a private medical institution that has a Memorandum of Understanding (MoU) with NACO for a private-sector partnership to expand HIV related services. USG will provide support to develop KIMS as a learning site for capacity building of the private sector in implementing HIV/AIDS programming. The training will increase capacity of various partner institutions under the NACO-private sector partnership program to provide pharmaceutical management. The program will address effective referrals to the free ART program supported through the government to reduce the likelihood of resistance to first-line ART. Additionally, a customized training package will be planned for capacity building of 500 pharmacies and chemists located around the private medical institutions that have a MoU for private-sector collaboration with NACO in the USG-priority states to support the country's first assessment of private sector ART. The package will include training to establish a system for collection, collation and calculation of volume of ARVs being dispensed from the private sector; and support training of pharmacists and chemists in their role for a concerted response to ART management. The project will work in close collaboration with the pharmaceutical companies that manufacture ARVs to identify champions among the medical/pharmaceutical representatives who will be trained as peer leaders.

Activity 4: Improve procurement efficiency at the district level

The project will support the capacity building of the district procurement program at the level of the ART centers in select high-burden districts of USG priority states. District surgeons and medical

superintendents who are currently authorized by the government for the decentralized procurement will be trained in forecasting, procurement protocols in adherence with national guidelines and logistic management of drugs and supplies. The training will facilitate the continuous availability of critical drugs at the time and in the quantity required including supplies for basic microscopy including availability of critical stains needed for TB diagnosis such as Acid-Fast Bacilli (AFB) and basic serology at the ART or community care centers located at the district level.

Implementing Mechanism Indicator Information

(No data provided.)

USG Management and Operations

1.

Redacted

2.

Redacted

3.

Redacted

4.

Redacted

5.

Redacted

Agency Information - Costs of Doing Business
U.S. Agency for International Development

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
Computers/IT Services				18,000	99,000	117,000
ICASS				45,800	63,800	109,600
Management Meetings/Professional Developement				25,000		25,000
Non-ICASS Administrative Costs				138,000	27,500	165,500
Staff Program Travel				80,000	150,000	230,000
USG Staff Salaries and Benefits				168,200	509,700	677,900
Total	**0**	**0**	**0**	**475,000**	**850,000**	**1,325,000**

U.S. Agency for International Development Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHCS (State)		18,000
Computers/IT Services		GHCS (USAID)		99,000
ICASS		GHCS (State)		45,800
ICASS		GHCS (USAID)		63,800
Management Meetings/Professional Developement		GHCS (State)		25,000
Non-ICASS Administrative Costs		GHCS (State)		138,000
Non-ICASS Administrative Costs		GHCS (USAID)		27,500

U.S. Department of Defense

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
Computers/IT Services				200		200
ICASS				3,100		3,100
Non-ICASS Administrative Costs				3,972		3,972
Staff Program Travel				6,000		6,000
USG Staff Salaries and Benefits				13,000		13,000
Total	**0**	**0**	**0**	**26,272**	**0**	**26,272**

U.S. Department of Defense Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHCS (State)		200
ICASS		GHCS (State)		3,100
Non-ICASS Administrative Costs		GHCS (State)		3,972

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
Capital Security Cost Sharing			276,493	48,928		325,421
Computers/IT Services			172,765	23,035		195,800
ICASS			247,500	33,000		280,500
Institutional Contractors			200,000			200,000
Management Meetings/Professional Developement				25,000		25,000
Non-ICASS Administrative Costs			105,176	98,743		203,919
Staff Program Travel			396,000	48,500		444,500
USG Staff Salaries and			1,131,489	47,794		1,179,283

Benefits						
Total	**0**	**0**	**2,529,423**	**325,000**	**0**	**2,854,423**

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention Other Costs Details

Category	Item	Funding Source	Description	Amount
Capital Security Cost Sharing		GAP		276,493
Capital Security Cost Sharing		GHCS (State)		48,928
Computers/IT Services		GAP		172,765
Computers/IT Services		GHCS (State)		23,035
ICASS		GAP		247,500
ICASS		GHCS (State)		33,000
Management Meetings/Professional Developement		GHCS (State)		25,000
Non-ICASS Administrative Costs		GAP		105,176
Non-ICASS Administrative Costs		GHCS (State)		98,743